Occupational governance and the dynamics of change - a comparative analysis of nursing in Britain and Germany

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Declaration

I declare that this thesis has been composed by me and that the work contained within it has been conducted by me.

Viola Burau

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As somebody who became interested in nursing without any professional training in that area, I greatly benefited from the insights of practitioners. Despite tight schedules many experts in nursing were available for interviews. Their views gave me a better understanding of the salient issues in nursing and the many ways in which nursing is affected by current developments in health care. Similarly, two local provider units of community care allowed me to examine potentially contentious decisions in their organisations. I was able to speak to managers and nurses who gave away part of their valuable 'time-together' for focus groups. Together with doctors and representatives of purchasing organisations they brought to life an initially rather abstract topic. Also, the wide range of their views gave me an idea of the complexity of the politics at micro level.

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Viola Burau

Abstract

The research analyses the occupational governance of nursing, that is the ways in which nursing as an occupation is governed, and how this is influenced by health systems. Britain and Germany provide an interesting comparison: while nursing in both countries is confronted with the challenge of meeting increasing demands in a climate of cost containment the institutions of health care differ. The study challenges a generic understanding of occupations. It argues that the ways in which occupations are governed vary, reflecting the institutional context they are embedded in.

The study begins by examining the occupational governance of nursing from a macro-perspective. It then reports on a micro-case study of the occupational governance of internal boundaries, which focuses on the interface between staff with different levels of training. The study draws on primary and secondary sources and interviews. The data for the case study was collected from two local providers of domiciliary care services in Britain and Germany.

The macro-analysis identifies legalism, self-regulation and micro-politics as different though inter-related types of governance. The comparison across the two countries concludes that the occupational governance of nursing is more cohesive in Britain, while it is more fragmented in Germany. But at the same time, the micro-analysis of internal boundaries stresses the complexity and ambiguity of the occupational governance of nursing. It suggests that in the German case governance has strong legalistic elements, which makes it more centralised and standardised. By contrast, governance in its British counterpart is more localised. These institutional differences also influence the type and extent of involvement of individual actors. In summary, the multi-level analysis highlights the similarities and differences of the occupational governance of nursing in Britain and Germany.

Glossary

Some of the key terms of this study are listed, particularly those which have specific meanings in the context of the comparison between Britain and Germany. The terms are defined broadly and are explained in more detail in the relevant chapters.

ambulatory care	health care provided outside hospitals, typically by doctors in their own practices (⇒ office-based doctors); in Britain also referred to as "primary care"
community (health) care	generally defined as health care provided outside hospitals, typically by nurses rather than doctors; care settings range from the patient's home and day centres to residential homes; in the context of the case study defined as care of the elderly delivered in domiciliary settings (⇒ community nurses, domiciliary care)
community nurses	generally defined as nursing staff practising in community settings (⇒ community care); in the context of the case study defined as nursing staff providing care of the elderly in domiciliary settings (where only the British case is referred to, the term "district nurses" is used)
domiciliary care	health care provided in the patient's home (⇒ community care)

first-level education	initial training, leading to general nursing qualifications
second-level education	subsequent and more specialised training, leading to additional qualifications
grade-mix	the mix of nursing staff with different levels of training within a given work setting, such as a hospital ward or community care team
internal boundaries	in the context of the case study refers to the interface between nursing staff with different levels of training, particularly that between qualified and non-qualified staff
local level/locality	in the context of the case study describes the local provider organisation and its immediate environment; in the German case the local level/locality is the local provider of community care and office-based doctors, whereas in the British counterpart it also includes the local GP practices as the purchasers of district nursing services
micro-politics	decisions taken by local actors and/or front-line practitioners; also as opposed to formal provisions, for example legislation and contracts
occupational governance	the ways in which occupations are governed across different levels and the institutions and actors involved

office-based doctors	doctors practising outside hospitals, typically in their own practice (⇒ ambulatory care); where only the British case is referred to, the term "general practitioner" (GP) is used
qualified	nursing staff whose training has led to a (full) qualification in nursing; in the German case this does not include enrolled nurses (*Krankenpflegehelfer/in*), who despite having a qualification are not formally recognised as "qualified" (*examiniert*); non-qualified staff might have had (formal) training, but they do not have a nursing qualification; an example are health care assistants in Britain

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INTRODUCTION

Nursing plays a central role in the provision of health care. It is the single largest occupation in European health systems. In general hospitals, for example, there are two to four times more nurses than doctors (Versieck *et al.*, 1995: 54). Thus, nursing is an integral part of health systems and health systems are important for understanding nursing. Current debates about health care, however, are dominated by issues of cost efficiency/containment, reform and the interests of doctors (cf. Saltman *et al.*, 1998), while nursing only seems to reach the agenda in times of crisis. These often take the form of concerns over shortages of qualified nursing staff and they lead on to more general discussions about nurses' pay, working conditions and the reform of nursing education (cf. Salvage and Heijnen, 1997; Versieck *et al.*, 1995). The relationship between nursing and health systems then, is paradoxical: although nursing is at the heart of the provision of health care, it appears to be at the margins of the health policy agenda.

At the same time, the relationship between nursing and health systems is dynamic and subject to change resulting from the dual challenge of meeting increasing demands in a climate of cost efficiency/containment. Following changes in demographic and epidemiological patterns, the prevalence of chronic illnesses is expected to increase, while the number of carers and nursing students is likely to fall (cf. OECD, 1996). This has implications not only for the amount and the type of (professional) care needed. These developments also highlight the limits of the medical model of health and illness with its focus on crisis intervention. At the same time, European health systems have seen major reforms in recent years which have stressed the primacy of cost efficiency and containment (cf. Ham, 1997a). This encourages a closer scrutiny of what nursing does and the personnel costs involved.

Interestingly, both the paradoxical relationship between nursing and health systems and the dual challenge of meeting growing demands in the context of cost

efficiency/containment emphasise the similarities across countries. This is surprising considering the very different institutional settings of health care in Europe, ranging from national health to social insurance systems. Taken together, these three sets of observations make a case for analysing nursing and for adopting a comparative approach. The comparative analysis of nursing is also interesting in the context of the comparative study of health care. This is concerned with comparing and contrasting health systems in different countries, exploring the ways in which health care is financed, provided and regulated (cf. Raffel, 1997). Considering its prominent role in the provision of health care, the relevant literature has been particularly concerned with analysing the medical profession (cf. Freddi and Björkman, 1989). A salient issue here is the relationship between doctors and the state in the context of both health governance and the governance of the medical profession. However, while nursing tends to be the single largest occupation in Western health systems the literature has largely failed to analyse it.

Against this background, the present study addresses two questions. Firstly, how is nursing as an occupation governed? Secondly, how is the occupational governance of nursing influenced by the institutional context of different health systems? Britain and Germany are chosen as two case studies for the analysis. Nursing is analysed from a dynamic perspective and the term governance implies that the 'operation' of nursing as an occupation is a complex process, potentially involving a wide range of actors and levels of interaction. The underlying assumption is that the ways in which nursing is governed are also influenced by country-specific institutions of health care.

The marginal position of nursing on the health policy agenda is mirrored in some of the relevant academic literature. More specifically, theories of professions and the comparative study of health care tend to constrain rather than enable the comparative analysis of nursing. Against this background the study begins by developing a framework for the analysis (chapters 1-3). This combines the comparative study of nursing with a multi-level approach, and more specifically, widens the concept of

occupations by considering the institutional context of health care. The ways in which this 'programme for research' is put into practice and the challenges it poses are outlined in the discussion of the methodology (chapters 4-6). The study then moves on to analyse different dimensions of the occupational governance of nursing in Britain and Germany, adopting a macro-perspective (chapters 7-11). It is argued that occupational governance is relatively cohesive in Britain, compared to Germany where it is more fragmented. This reflects differences in the institutions of health care and the role of the state in particular. Furthermore, the analysis stresses the importance of governance at the local level. Against this background and by way of illustration, the research then turns to a micro level case study of the governance of internal boundaries: that is, the interface between nursing staff with different levels of training (chapters 12-16). The analysis highlights the complexities and ambiguities of the occupational governance of nursing. In the case of Germany legalism renders governance more standardised, whereas its British counterpart is characterised by greater localism. In the conclusions the implications of the study for the analysis of nursing, theories and professions and the comparative study of health care are discussed.

Research contribution

Among the academic disciplines nursing studies naturally focuses most directly on nursing. It provides an abundance of literature on different aspects of nursing, ranging from education and management to the practice and ethics of caregiving. However, nursing studies tends to be strongly practice-oriented and it is mainly concerned with research *for* rather than *about* nursing. As such, it falls short of research which adopts a comparative or multi-level approach. At the same time, other relevant strands of the social sciences literature, notably theories of professions and the comparative literature of health care, have largely failed to analyse nursing in its own right. Against this background, the study addresses the question of how nursing can be analysed in the context of these debates. Adopting a comparative and multi-level approach, it potentially challenges prevailing conceptualisations of occupations.

Against this background, it is not surprising that there is hardly any research which compares nursing across different countries. On the one hand the sociology of professions often tends towards a comparison of locales or occupations/professions, rather than countries. In political science, on the other hand, the comparative study of health care has expanded considerably, partly in the context of crisis and partly in the context of European integration. But it does not address nursing. Nevertheless, a comparative approach can make potentially-interesting contributions to the understanding of nursing. Besides exploring nursing in different countries, a comparison has explanatory value. The systematic analysis of similarities and differences may help to identify those factors shaping nursing and how it is governed as an occupation. Moreover, the study of nursing also expands the scope of the existing comparative analyses of health.

Moreover, there is a lack of research which embraces different levels of analysis. This approach seems important for a full understanding of nursing and its occupational governance. An exclusive focus on the macro level ignores the importance of micro-politics: that is, of arrangements and decisions at the level of local provider units and frontline-practioners (cf. Haug, 1995: 97). Similarly, a micro level analysis of nursing cannot account for the ways in which the wider institutional setting of health care influences nursing and the ways in which it is governed as an occupation (cf. Witz, 1994: 39)[1]. Combining different levels of analysis also acknowledges the fact that nursing is primarily present at the local level of practice, but that it is likely to be affected by the macro-institutions of health care, reflecting nurses' prominent role in the provision of health care.

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[1] Similarly, in their comparative study of social work Hetherington *et al.* (1997: 43) argue "A description of a social work system is almost impossible to understand unless attached to a case; equally, it is difficult to get a proper understanding of social workers' actions and decisions without any knowledge of the surrounding system."

CONCEPTUALISING NURSING

The following set of chapters aims to develop a framework for the comparative analysis of nursing. It begins by reviewing the literature on theories of professions (chapter 1). It is argued that the predominantly generic understanding of professions tends to constrain rather than enable the comparative analysis of nursing. Instead of assessing whether nursing in different countries conforms to a certain ideal type, it may be more interesting to adopt a dynamic perspective and to ask how nursing as an occupation operates. This suggests adopting an inductive perspective, which can be operationalised by taking an actor-centred approach. In the context of the comparative analysis, it can be broadened by analysing the institutions of health care in which actors operate. Thus, the next chapter reviews different approaches to understanding health care in a comparative context (chapter 2). Although the relevant literature largely fails to analyse nursing, the institutionalist approach combined with the concept of governance provides a basis for examining the relationship between nursing and health systems and for identifying the underlying power relations. Finally, the arguments of the two literature reviews are drawn together and a framework for the comparative analysis of nursing and its occupational governance is drawn up (chapter 3). It aims to combine different levels of analysis by integrating the concepts of occupations and health systems.

1 Professions, nurses and comparison

The study aims to analyse nursing in Britain and Germany. Irrespective of the differences the comparative perspective is likely to highlight, nursing across different countries has in common the fact that it is a collective entity, consisting of people doing similar types of work. This links the analysis of nursing to the analysis of occupations. Here, sociological theories of professions provide an obvious starting-point. This chapter explores different theories of professions and the question of whether and to what extent they can contribute to the understanding of the occupational governance of nursing in a comparative context[1]. It is argued that theories of professions constrain, rather than enable the analysis, as they are still largely modelled upon a generic understanding of professions. By contrast, feminist writers stress the importance of gender in the division of labour in health care and in the development of professions[2]. In addition, the growing body of historical analysis suggests that the dynamics of professions tend to be specific, in that they are firmly embedded in the societal, political and economic circumstances of a particular point in time. The historical approach has also encouraged a comparative analysis of professions[3]. It focuses on the ways in which country-specific contexts influence the development of professions, as well as the understanding of professions itself. These criticisms of a generic understanding of professions call for an alternative approach. It is argued that one option is to proceed inductively. This means beginning with empirical analysis and only subsequently asking how its findings can be

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1 For a broad overview of different strands of the debate cf. Macdonald (1995).

2 Cf. Carpenter (1993), Davies (1995), Hearn (1982), Riska (1993), Witz (1992, 1994).

3 For an overview of both debates cf. Freidson (1994: 4ff); on the comparative and historical analysis of professions cf. Burrage and Torstendahl (1990), Heidenheimer (1989), Torstendahl and Burrage (1990).

conceptualised theoretically. Thus, the initial problem is defined as empirical rather than abstract in its nature[4].

The chapter begins by analysing how theories of professions can contribute to understanding nursing as an occupation. It suggests that the scope of most approaches is limited: they take the notion of professionalism rather than nursing itself as their starting point and they focus on the attainment of a certain end-state, whereas the *different* ways in which occupations function and work are neglected. Subsequently, it is explored how theories of professions can contribute to a comparative analysis. Again, the scope is limited, as these theories are based on a culturally-specific, that is Anglo-American, understanding of professionalism. The conclusions argue that the comparative analysis of the governance of nursing requires a flexible conceptual framework which starts off with a variety of possible empirical findings rather than with a culturally, historically and gender-specific ideal typical notion of professionalism. Such an inductive approach can be operationalised by adopting an actor-centred perspective. Finally, it is emphasised that the comparative analysis can be further broadened by considering the institutional context of health care in which nursing is embedded. This suggests adopting a multi-level approach, combining the analysis of occupations and health systems. The underlying aim, however, is not to discard the concept of professionalism altogether. Instead, the inductive, actor-centred approach may offer a fresh look and as such it may feed back into the theoretical debate.

Theories of professions and the analysis of nursing

Until recently the sociology of professions has hardly analysed nursing in its own right. It is argued here that this can be put down to the particular focus of the

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[4] The underlying plea to strengthen the empirical analysis of professions is echoed by Saks (1983: 16). He argues that one of central weaknesses of the taxonomic, neo-Weberian and Marxist approaches alike is their lack of empirical rigour.

analytical tools employed: to view nursing through the lenses of professionalism limits the analysis at least in two respects[5]. Professions are an important, but by no means the only way of organising expertise. As a result of this neglect, the analysis focuses almost entirely on the questions as to whether nursing is or can become a profession or, alternatively, how it tries to attain professional status. An early example is Etzioni (1969). He argues that occupations such as nurses or teachers fail to meet the criteria of professions because their work can be integrated more easily into organisations, and is, therefore, less autonomous. He characterises these types of occupations as "semi-professions"[6]. Given his analytical framework this conclusion is logical, but it falls short of asking what nursing is, if not a profession: "Rather than presupposing the sociological significance of professions as a category, we should be asking what kinds of occupations there are" (Dingwall, 1983: 12).

Focusing on professionalism is not only problematic *per se*, but also as it is modelled upon dominant professions such as medicine and law (cf. Abbott and Wallace, 1990: 1ff). A classic example is Freidson's (1970) influential definition of professions in terms of autonomy and dominance of the division of labour. Whereas the first aspect refers to the control over the substance of work, the second denotes control over other occupations in the division of labour. Similarly, Larson (1977: xvii) defines professions as a "monopoly of expertise in the market". The notion of monopoly renders the nature of these criteria absolute. This leads to an analytical perspective which has difficulties in conceptualising the nuances of a given division of labour. Instead it is essentially confined to a dichotomy between professions on the one hand and non-professions on the other[7]. Consequently, nursing has largely been analysed in terms of its subordination to the medical profession, that is as a "semi-" or "para-

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5 As early as 1972 Johnson (1972: 89) described these limitations rather drastically as a "conceptual strait-jacket". For a critical discussion of theories of professions and their treatment of nursing, cf. Wicks (1998: 7ff), Wilkinson and Miers (1999).

6 For a powerful critique of Etzioni cf. Parkin (1979: 102ff).

7 Not surprisingly, Freidson (1970: 57ff) regards it as almost impossible for nurses to escape the system of medical dominance and their subordinate position within it.

medical" profession, and has been marginalised in the sociology of professions (Carpenter, 1993: 95f).

So far it has been suggested that the focus on professionalism does not grasp the entire range of features which are important to understanding nursing and how it is governed as an occupation[8]. Nevertheless, some approaches within the neo-Weberian school (and beyond) partly widen the analytical perspective. One of the earliest is that of Johnson (1972). He focuses on occupational control, and regards professionalism as a specific type of organising occupations. In contrast, Parkin (1979) defines professions in terms of social closure, that is the exercise of power. Interestingly, he distinguishes between different types of social closure: in addition to "exclusion", which is employed by dominant occupations, he also includes "usurpation", that is the use of power in an upwards direction, and "dual social closure" as a combination of the two. As a result the analytical scope is broadened and it can directly account for the activities of non-dominant occupations such as nursing[9]. Similarly, Abbott (1988) defines professions in terms of jurisdiction, understood as a general expression of control. Here, the concept of dominance is treated as a special case (Abbott, 1988: 87). In addition, the emphasis on "disputes" encourages a detailed analysis of the different measures employed to retain or achieve jurisdiction. Finally, Freidson (1983) suggests widening the analytical focus by introducing a clear 'division of labour' between theories of occupations on the one hand, and theories of professions on the other. Whereas the former would provide a general analytical framework, the focus of the latter would be more specific, dealing exclusively with professions[10].

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8 Davies (1992) makes a similar point concerning the concept of functional autonomy.

9 Parkin (1979: 101ff) elaborates this aspect himself in some detail. Not surprisingly, therefore, this approach has been used to analyse nursing and its occupational development; cf. Hugman (1991: 82ff) and Ramprogus (1995). Moreover, in her analysis of the historical development of nursing Witz (1992) introduces a gendered version of social closure, which pays particular attention to the occupational strategies of subordinate groups.

10 The plea for a "theory of occupations" is echoed by Witz (1992: 5).

A different type of critique of mainstream theories of professions is brought forward by feminist writers. They argue that the notion of professionalism is gendered and modelled upon dominant male professions. Not surprisingly, compared with other approaches, they provide a lever to address more explicitly the analysis of nursing. A first strand of the literature explores the gendered division of labour in health care by taking the distinction between paid and unpaid work as its starting-point[11]. It emerged from earlier debates about the day-to-day reproductive work of households and of informal care more specifically (cf. Graham, 1983)[12]: while paid work is traditionally associated with the public sphere, being regarded as 'masculine territory', unpaid work is located in the private ('feminine'). Care is a prime example of this type of work, although its nature is dualistic. It consists of the instrumental performance of tasks ("caring about") and emotional inter-personal skills ("caring for") (Ungerson, 1983, 31f). In order to capture this double-sidedness, Graham (1983) also refers to care as a "labour of love". If one follows this argument, the nature of nurses' work becomes paradoxical: while it is formally paid work, it is strongly associated with the realm of unpaid "female labour of love" (Robinson, 1989: 158f)[13]. The ambivalence of the nature of nurses' work is further enhanced by the fact that the majority of hands-on care is provided by lower qualified nurses or by informal carers. Thus, there is a "... catch 22 here; if anybody can do nursing we cannot define what is special about it, but we cannot demonstrate its specialness, because many different people are doing it" (Davies, 1995: 90). Nurses, then, are stuck in-between both worlds: doing paid work, but work which is strongly associated with a low status, "female labour of love". In summary, these feminist authors criticise the mainstream

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11 Similarly Davies (1995), Gough *et al.* (1994), Hugman (1991) and Salvage (1985).

12 For a critical review of the debate cf. Graham (1991).

13 Similarly, in the context of the German debate Ostner and Beck-Gernsheim (1979: 68ff) distinguish between "domestic" (*hausarbeitsnahe*) and "occupational" (*Berufsarbeit*) elements of caring. Whereas occupational work is characterised by a set of clearly restricted and identifiable tasks, the nature of domestic work is more irregular. It has to respond to less predictable immediate human needs. Nursing assumes an intermediate position, as it incorporates elements of both types of work. This ambivalence is also reflected in conflicting demands: in the context of hospital care, for example, nurses are subject to the drive towards

understanding of the concept of professions by arguing that the analysis of nursing presupposes an understanding of the interdependent relationship between formal and informal care (cf. Robinson, 1989: 172f).

In contrast, Witz (1992)[14] suggests that the distinction between formal and informal labour does not succeed in fully conceptualising the gendered nature of work: the analysis tends to be static as the gender of the practitioner is considered as "already being given" and it is based on a simplistic understanding of women's roles. Instead, she argues for an analysis of the ways in which gender roles and relations are constructed and reproduced in the domain of paid work. The hierarchy between feminine and masculine work, then, is no longer seen as being rooted in the differing natures of work itself. Instead, the hierarchy is constructed in that it is the outcome of historically-specific power struggles (similarly Wetterer, 1993: 52). Consequently, the gender rather than the nature of the work determines the status and level of training/pay of a certain type of work. This is echoed by Crompton (1987), who argues that status and skills are independent: "... if a professional occupation, however skilled in a technicist sense, has initially emerged as a female occupation it will have been ranked relatively low in respect to material rewards" (Crompton, 1987: 422). Similarly, in her analysis of the historical development of nursing in Germany, Bischoff (1994a) argues that nursing was 'made' a female occupation in the 19th century to counterbalance societal contradictions existing in bourgeois (*bürgerliche*) society. In the context of the debate about theories of professions, Witz's (1992) work is particularly interesting: while she follows Parkin and conceptualises "professional projects" as strategies of occupational closure, she suggests "genderising" his approach. Thus, she outlines closure strategies which are specific to subordinate (female) occupational groups and which reflect the closure

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rationalisation. At the same time they have to respond to the immediate physical, psychological and social needs of patients which cannot be postponed.

[14] Similarly, Wetterer (1993).

strategy adopted by the dominant occupational groups[15]. In summary, while these two strands of the feminist literature differ in their views about the origins of the hierarchy between masculine and feminine work, they both stress the gendered nature of the concept of professionalism and the corresponding division of labour in health care[16].

The approaches outlined above partly move away from a generic understanding of professions and thereby widen the analytical perspective. As such, they potentially provide a lever for analysing nursing. They do so either by broadening the understanding of professions itself, by shifting the focus to occupations and reserving the concept of professions to a limited number of cases or by pointing to the gendered nature of professions. The next section indicates, however, that the method of comparison further complicates the search for a suitable conceptual framework for analysing the occupational governance of nursing in a comparative context.

Theories of professions and comparison

So far it has been argued that theories of professions tend to constrain rather than enable the analysis of the governance of nursing. These difficulties are further exacerbated when pursuing a comparative approach, because of the cultural specificity of Anglo-American theories of professions[17].

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15 For schematic overview see Witz (1992: 45).

16 In this respect Hearn (1982) adopts a particularly radical approach. In equating professions with medical dominance, he stresses the important role professions play in the process of maintaining and developing patriarchy.

17 In this respect it is interesting to note that Anglo-American theories of professions have hardly been a subject of debate in Germany, except in the early 1970s (cf. Luckman and Sprondel, 1972; Hesse 1972). While the Anglo-American debate is sociological in its outlook and concerned with the development (and making) of professions, the corresponding German debate focuses on the process of occupational socialisation and is strongly influenced by the professional concerns of socialpedagogs and social workers (Wetterer, 1993: 11). Cf. Alisch *et al.* (1990), Dewe *et al.* (1992).

In a comparative context the following assumptions underlying mainstream theories of professions are especially important: the state and professions are perceived as two separate entities and their relationship is conceptualised as a dichotomy between autonomous professions on the one hand and the interventionist state on the other (Johnson, 1995: 9)[18]. Thus, independent practice is regarded as the characteristic form of professional employment, whereas working in bureaucratically-structured organisations is considered as the antithesis of professionalism[19]. A prime example of this way of thinking is Freidson's (1970) distinction between technological and social/economic autonomy, that is between micro and macro-control over the terms of work. Such a distinction, however, is paradoxical: it is only by considering technological autonomy to be the core of professionalism that the notion of professional independence from the state can be upheld (Johnson, 1995: 10). This dualism prevents any closer analysis of the actual relationship between professions and the state[20]. Professionalisation, then, is seen as a process from *within* the occupational group in question and is typically understood in terms of social closure from markets (Holmwood and Siltanen, 1992: 8). Larson, for example, defines professionalisation "... as the process by which producers of special services ... (seek) to constitute *and control* a market for their expertise" (Larson, 1977: xvi; emphasis in the original). Professionalism, therefore, is regarded as a monopoly of expertise in the market. Not surprisingly, the state's role vis-à-vis professions is seen as minimal in that it is confined to the state legitimising already existing professional closure. Parkin (1979: 48), for example, characterises the principal means of social closure, that is property and credentials, as "state-*enforced* exclusionary practices"[21]. The state, thus, is merely perceived as an "environmental factor". Interestingly, Larson

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18 For a detailed analysis of the ways in which different theoretical approaches treat the relationship between state and professions see Johnson (1995).

19 For a critical overview of this argument cf. Davies (1983), Freidson (1994: 61ff), Light (1995).

20 It is argued that neo-Weberian theories of professions mark the starting-point of a more politically and, therefore, state-oriented analysis of professions as they focus on conflict; cf. Björkman (1982: 412), Collins (1990: 14). But is seems that this potential has not been fully realised (Johnson, 1995: 7).

(1977: xvii) acknowledges that it is not by accident that "... the model of professions developed its most distinctive characteristics and the most clear-cut emphasis on autonomy in the two paramount examples of laissez-faire capitalist industrialisation ...", that being Britain and the US. Finally, seeing professions as being distinct from both market and state leads to a preoccupation with latent threats to professional independence: either by the "bureaucratisation" or the "proletarianisation" of professional labour[22]. The first aspect refers to the weakening of professional market shelters. As a result professional practice, income and status become more and more similar to those of other workers. The second phenomenon has similar effects on professions, but a different cause, that being the growing importance of principles of bureaucratic organisation such as specialisation or formal codification of procedures.

These assumptions only problematic when confronted with empirical findings of analyses of Anglo-American professions[23], but are even more so when applied to comparative analysis. As the co-existence of professions and a 'strong' state is precluded, this framework has only limited meaning for countries such as Germany and France where the state has traditionally assumed a more interventionist role. Ultimately, it leads to the simplistic conclusion that the occupations in these countries cannot achieve 'proper' professional status (Daheim, 1982: 378; McClelland, 1990: 98). Alternatively, it can be argued that the 'problem' of German or French professions is not so much the existence of strong states, but rather that their history does not conform "... to that of the Anglo-American world, the experience of which has informed so much of the theory of modern professions and professionalization" (McClelland, 1990: 112). The interesting question, then, is not

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21 It is only in the case of occupations which fail to achieve full social closure that the state assumes a greater role. Here, Parkin even speaks of "creations of bureaucracy" (1979: 106).

22 For a critical overview of these neo-Marxist debates cf. Freidson (1994: 128-146), Holmwood and Siltanen (1992: 8ff), Murphy (1990).

23 Authors such as Davies (1983) and Holmwood and Siltanen (1992) emphasise that the presumed relationship between professions and markets, the state and bureaucracies does not necessarily stand up to the findings of empirical analysis.

whether continental professions conform with the Anglo-American ideal type, but what their actual features are.

In addition, these assumptions impede the analysis of nursing: by defining professions and state/bureaucratic organisations as mutually exclusive, Anglo-American theories of professions face difficulties in accounting for the fact that nurses predominantly do not work as independent practitioners. They fail, therefore, to analyse nursing in its own right. At this point it also becomes clear that the issues of nursing and comparison are closely related. Insofar as the comparative approach questions country-specific assumptions about professionalism and demands their reassessment it potentially opens up the possibility for a more thorough analysis of nursing.

The preceding argument, then, raises the question of which theoretical/conceptual frameworks are more suitable for comparative analysis. One obvious and widely discussed option is simply to consider the assumptions outlined above as ideal types and to add others. Thereby, the existence as well as the importance of country-specific differences is explicitly acknowledged and the Anglo-American model is no longer treated as generic. It is argued, for example, that it would be useful to distinguish between an Anglo-American and a Continental ideal type of professions[24]: the former "... stresses the freedom of self-employed practitioners to control working conditions ...", whereas the latter emphasises "... elite administrators possessing their offices by virtue of academic credentials" (Collins, 1990: 15). This is also reflected in different types of professionalisation: whereas the Anglo-American model focuses on forming "private government" within an occupation, the Continental variant is a political struggle for control within an élite bureaucratic hierarchy (Collins, 1990: 17). Similarly, McClelland (1990: 107f) distinguishes

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[24] Cf. Collins (1990), Freidson (1983: 22ff), Heidenheimer (1989), McClelland (1990), Rueschemeyer (1983).

between "... professionalization 'from within' (successful manipulation of the market by the group) and 'from above' (domination of forces external to the group)"[25].

However, the use of country-based ideal types in comparative analysis is not without problems. As the discussion of the Anglo-American ideal type indicates there is the danger that the analytical scope is *de facto* limited. Collins (1990: 15), for example, points out that the two models outlined above are not only idealised and ideologically defined, but are also confined to élite status groups. Furthermore, ideal types tend to stress differences rather than similarities between countries. These differences are so significant that the ideal types appear to be each other's antithesis rather than variants of the same phenomenon. As a result, they may encourage debates which are separated by countries and which are not necessarily comparative in their nature. Finally, the ideal types focus exclusively on country-specific differences which are only one aspect of the explanation. Analysing the historical development of medicine and law in Britain, Germany and the US, Heidenheimer (1989: 534ff), for example, points out that the variation *between professions* is sometimes as significant as that *across countries*. Bertilsson (1990) and Holmwood and Siltanen (1992: 2ff) go even further to claim that the various stages of citizenry have a far greater impact on professions and their practice than differences between individual countries[26]. In this context Bertilsson (1990: 119, 127) speaks of a constitutive relationship and attributes the growing importance of 'new' professions, such as nursing, to the expansion and institutionalisation of social rights.

Nevertheless, the debate about the ideal type approach is valuable in that it stresses the importance of the state. This coincides with a trend in the sociology of professions to look at the wider political, economic and societal context in which

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25 Also see Krüger (1983).

26 In so doing they shift the focus from actors to social structure and stress the important role of professions in administering welfare states. This notion of interdependence is taken up by the approaches discussed below which aim to bring the state back into the analysis of professions.

professions are embedded and to "bring the state back in"[27]. Using Foucault's notion of "governmentality" Johnson, for example, stresses the symbiotic relationship between professions and the state: "... expertise, as it became increasingly institutionalized in its professional form, became part of the process of governing" (1995: 9). Professions, therefore, cannot be understood without considering the state. Similarly, Frenk and Durán-Arenas (1993: 41) in their conceptual discussion of the relationship between the medical profession and the state emphasise that the forms of occupational control are becoming more diverse and that "... in these forms the state ... (occupies) central positions of control."

Light (1995) and Burrage *et al.* (1990) argue in a similar vein: by defining professional development in terms of a political struggle between different actors, they not only acknowledge the central role played by the state, but their frameworks also accommodate varying arrangements between state and professions. In this context Light (1995) introduces the notion of "countervailing powers" which is based on the assumption that health care systems tend to gravitate towards an equilibrium. Thus, countervailing powers reflect imbalances produced by professional dominance. More specifically, he suggests considering the following actors: professions, the state, patients and the medical-industrial complex. Similarly, Burrage *et al.* (1990) argue for focusing on the key actors who are engaged in the struggle of occupations to establish themselves, notably practising members of an occupation, academic members of an occupation, the state and clients. At the same time, it is acknowledged that actors have different resources and interests and employ different strategies.

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[27] This trend can also be interpreted as a convergence of sociology and political science; cf. Björkman (1982), Freidson (1994: 6). An example of the second type of literature is the analysis of the regulation of the medical profession in the UK, the US and Germany by Moran and Wood (1993). They emphasise (1993: 4) that "States are central to the working lives of doctors." and go on to argue that politics lies at the heart of professional regulation. By defining regulation as politics, they highlight the importance of differences and thereby refute the idea of a generic concept of profession (Moran and Wood, 1993: 31). Similarly, Freddi (1989), in an introduction to an edited collection on doctors and the politics of health governance, argues that medical autonomy is granted by the state. As states and their public and institutional environment differ, so does the autonomy of doctors.

They summarise their approach as follows: "By presenting the development of the professions as the interplay of four actors ... it (the analytical framework) gives primary place to politics. Since all actors involved depend on the state, and their actions are mediated by the state, the decisions and policies of the state towards professional knowledge and professional services are therefore a subject of particular importance" (Burrage *et al.*, 1990: 221).

Implications for the analysis

The preceding sections have looked at the ways in which theories of professions address the issues of nursing and comparison and the extent to which they can contribute to the comparative analysis of the occupational governance of nursing. The conclusions to be drawn from this analysis are two-fold: the framework of professions generally tends to impede rather than facilitate the analysis. This is particularly true for the classic, and still influential, approaches, such as that of Freidson (1970). At the same time, more recent frameworks do not provide 'ready-made' solutions to the problems outlined above and the comparative analysis in particular. While Parkin's (1979) concept of social closure, for example, can account for the strategies employed by non-dominant occupations such as nursing, it fails to explore in more detail the possible role of the state. Similarly, in their analysis of the gendered nature of professions feminist writers tend to stress similarities. Thus, their argument provides little leverage for analysing the governance of nursing in a *comparative* context.

In contrast, the approaches outlined at the end of the last section appear to be more suitable to the present research: by "bringing the state back in" they acknowledge the differences between countries and open up the way for a more empirically-oriented analysis of professions, as opposed to the testing of the validity of an ideal type. Thereby, they implicitly suggest adopting an inductive approach. This does not mean discarding the concept of professionalism altogether, but instead the choice of a different starting-point. In so doing the analytical perspective is widened and the

possibility of arriving at a more refined understanding of both the occupational governance of nursing and the phenomenon of expertise itself is opened up[28]. The core of this argument, then, is to begin with empirical analysis. Following the inductive method, though, does not necessarily mean treating professionalism as a "folk concept" (Freidson, 1983: 27ff). Instead, it suggests the need for a *theoretically informed* map in which nursing can be located. This attempts to address the dilemma that a definition of occupations is both a prerequisite for and the outcome of the analysis. The central advantage of such a framework, then, is that it provides a *single* map in which nursing in *different* countries can be located. As put forward by Burrage *et al.* (1990) and Light (1995) an inductive understanding of occupations can be operationalised by adopting an actor-centred approach. Thus, the occupational governance of nursing is understood in dynamic terms, notably as a political struggle between different actors including the state. By stressing the role of the state this type of approach also encourages an analysis of the wider political, social and economic context in which occupations operate. The importance of these contextual factors is also highlighted by the comparative perspective and the differences between countries. This suggests broadening the comparative analysis of occupations by exploring the health systems of which nursing is part of. Possible conceptual tools are discussed in the following chapter.

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[28] Interestingly, Burrage *et al.* (1990: 205) argue that although the concept of professionalism is problematic from an analytical point of view, it remains an important point of reference in public debates as well as in the claims made by occupations themselves. Thus, they suggest including the notion of professionalism as a political phenomenon in the analysis.

2 The comparative study of health care

This chapter aims to explore different ways of conceptualising the institutional context of health care in which nursing is embedded. It reviews the relevant political sciences literature and the different approaches to analysing health care in a comparative context. These range from understanding health care as systems and policy to examining the political implications of health institutions and the broad context of the governance of health care. But with their focus on the level of systems and 'visible' decision-making, they tend to impede the analysis of nursing. However, an institutionalist approach may provide a framework for exploring how nursing is embedded in health systems and for examining the underlying power relations. This requires broadening the focus of the analysis and, it is argued, that the concept of governance can be used as a complementary conceptual tool. It can account for the multiple institutions, actors and, particularly, levels potentially involved in the governance of nursing.

The chapter begins by reviewing the literature on typologies of health care systems and argues that the underlying debate tends to be descriptive and technical in its nature. An alternative way of conceptualising health care is to adopt a policy perspective. Here, approaches can be distinguished according to whether they gravitate towards structure or agency-centred explanations. In contrast, the third section turns to the institutionalist perspective suggesting that it combines systems and policy perspectives on health care. It also emphasises the important role played by the state. The literature review is completed by discussing the concept of governance. It is argued that it broadens the institutionalist approach as it points to the complex nature of the process of governing. The conclusions suggest combining an institutionalist approach with the concept of governance, in order to analyse the multiple ways in which the broader context of health care influences nursing and the ways in which it is governed.

Health care as *systems*

In the comparative literature on health care a common approach is to use typologies of health care systems. These represent ideal types of specific sets of macro-institutional characteristics. Health care, then, is understood in terms of specific *systems* of financing, delivery and regulation[1]. The development of this approach has been particularly influenced by a series of OECD studies (OECD, 1987, 1992). The 1987 study (OECD, 1987: 24), which looks at the financing and delivery of health care in OECD countries, suggests a categorisation of health systems into three basic models. The national health service (or Beveridge) model is characterised by universal coverage, funding out of general taxation and public ownership and/or control of health care delivery. In contrast, the social insurance (or Bismarck) model is characterised by compulsory, universal coverage as part of a system of social security. It is financed by employer and employee contributions, through non-profit insurance funds, and the delivery of health care is in public or private ownership. Finally, the private insurance (or consumer sovereignty model) is characterised by employer-based or individual purchase of private health insurance. It is financed by individual and/or employer contributions and health delivery is in private ownership. These ideal types are exemplified by Britain and Italy; France and Germany; and the United States respectively. While this early study focuses on modes of delivery and financing, as well as the degree of consumer sovereignty, a later study (OECD, 1992) looks more closely at the implications of these models for the regulation of health

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[1] The notion of health systems tends to be modelled upon the comparative literature on welfare states. Here, the work of Esping-Andersen (1990) has been particularly influential. His notion of welfare-state regime is based on a critique of understanding welfare states in terms of levels of expenditure, an approach which emphasises similarities in terms of macro indicators. In contrast, he stresses the importance of differences between countries and identifies three types of welfare-state regimes: "liberal", "conservative", and "social democratic". One important strand of criticism levelled at the "three faces of welfare capitalism" argues that the typology is modelled upon Anglo-Saxon, continental and Scandinavian countries, while it is hardly applicable to Southern Europe (Ferrera, 1996; Leibfried, 1993, Lessenich, 1994). A more far-ranging critique is brought forward by Alber (1995), who points out that the comparative study of welfare states tends to focus on social transfer payments by the state, whereas the structure of the provision of services is often neglected. Chamberlayne (1993) addresses similar issues in her discussion of "cultures of care".

care. Focusing on the sources of financing and the methods of paying providers it examines the interaction between consumers/patients, first and second-level providers, insurers/third-party payers and governments.

This classification of health systems in industrialised countries has been used widely in comparative studies of health care[2]. More or less directly following the OECD studies, Wall (1996), for example, distinguishes between the "Beveridge", the "Bismarck" and the "modified market model". However, she also includes the "status" of health care. It ranges from being a "social service" in the Beveridge model and a "social right" in the Bismarck model, to being an "insurable risk" in the modified market model. Similarly, in his study of health care reform in Europe, Ham (1997b) focuses on modes of financing and delivering health care. Here, he distinguishes between public provision and funding (for example Britain and Sweden), public/private provision and public funding (for example Germany and the Netherlands), and private provision and funding (for example the United States)[3]. Finally, in her comparative study Bernardi-Schenkluhn (1992) relates the financing of health care to the structure of the political system more generally. Thus, she distinguishes between highly differentiated health care systems in federal states, which are based on self-government (for example, Germany and Switzerland), and politically integrated health care systems in centralised states (for example, Britain, Italy and France) (Bernardi-Schenkluhn, 1992: 688ff). Nevertheless, the degree to which the state has direct responsibility for funding remains the central characteristic.

However, conceptualising health care in terms of systems can be problematic. As stressed in one of the OECD studies itself, while there are considerable similarities in

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2 Beyond the studies discussed below also see Raffel (1997).

3 Ham's discussion of the 1992 OECD study is echoed by Ranade (1998) in her introduction to an edited collection on markets in health care.

terms of the financing and delivery of health care between the countries of one type, significant differences remain. Thus, "... none of these models provides a wholly adequate description" (OECD, 1987: 24). Alternatively, similarities between systems may be more significant than the differences between them. A different critique is provided by Moran. He stresses (1992: 79) that by focusing on the scale of the state's commitment to delivering welfare, and/or regulating access to welfare, these approaches attempt to define what the health care *is*. However, this is difficult as there is no agreed universal definition. Moreover, as health care is often defined as medical care, nurses are not necessarily visible at the level of systems. Typologies of health systems may therefore constrain rather than enable the analysis of nursing.

Health care as *policy*

While the concept of health systems is primarily concerned with the description of macro-institutional characteristics of health care, another important strand of the literature tries to understand health care from a policy perspective. There are different views as to how health policy can be explained and a general distinction can be drawn between structure and agency-centred approaches[4]. The underlying question is whether policy is determined by institutions or interests. In their discussion of different ways of understanding health policy, and the underlying distribution of power, Harrison *et al.* (1990) distinguish between neo-pluralist, public choice, neo-élitist and neo-Marxist theories[5]. Similarly, Ham (1992) identifies pluralist, Marxist,

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4 In general terms, Hay (1995: 189) explains that ideas about structure and agency reflect a "... deeper set of understandings about the relative autonomy of actors or agents in the settings in which they find themselves".

5 Their focus on theories of the distribution of power arises from a critique of the "shared version" of health politics. Its emphasis on incrementalism "... concentrates too much on the *foreground* of the actual decision process and says too little about the background *environment* which frames the action ..." (Harrison *et al.*, 1990: 12; emphasis in the original). In order to explain systematic inequalities underlying health politics it is necessary to "... go beyond the incrementalist 'frame', to a deeper level of analysis and theory, where the roots of power and influence may directly be addressed" (Harrison *et al.*, 1990: 13).

and structuralist approaches[6]. The following discussion focuses on the extreme points of the structure-agency continuum, that is pluralist and neo-élitist/structuralist perspectives. It is argued that the scope of pluralism, with its focus on visible decision-making, is limited as nursing is not necessarily involved in or explicitly the object of health policy-making. In contrast, neo-élitist approaches provide a basis for explaining why this is the case.

Pluralist theories stress the importance of "pressure group politics", that is the influence of and interaction between organised interests. While classical pluralism assumes that power tends to be widely distributed, and that all interests have potentially equal access to decision-making processes, neo-pluralists focus on networks of decision-making. These involve a limited number of actors. However, what both variants of pluralism have in common is that they are relatively close to the 'agency end' of the continuum and, as such, focus on the foreground of political action (Harrison *et al.*, 1990: 17). In contrast, neo-élitist/structuralist theories put greater emphasis on the structural aspects of policy. Élitist approaches maintain that power is disproportionately concentrated in the hands of a limited number of groups. There are variants of this argument. Corporatist approaches point to the close bargaining relationship between the state and a set number of organised interests. While liberal, or "interest corporatism", pays particular attention to the existence of formal relationships, Dunleavy's (1981) notion of "ideological corporatism" stresses the importance of informal relationships. Here, the cohesion of a community of decision-makers is promoted by a shared view of the world. This variant of corporatism potentially has particular relevance for the health care sector, as the "... central focus of most systems of ideological corporatism in advanced industrial societies is a profession" (Dunleavy, 1981: 8). Professions are likely to play a significant role in policy-making, not only because their ideology reflects an

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[6] For an overview of these theories also see Ham and Hill (1984), and Wilkinson (1999), who examines the concept of power more broadly.

altruistic ethos of respect for 'public interest', but also because of their relatively high degree of internal specificity and identity.

Conversely, Alford's (1975) structural interest theory assumes that there is considerable competition between élites. The specific feature of structural interest is that their degree of power does not *primarily* depend on whether or not they are organised: structural interests are "... served or not served by the way they fit into the logic and principles by which the institutions of a society operate" (Alford, 1975: 13f). He applies the notion of structural interests to health policy and distinguishes between professional monopolizers as dominant interests, corporate rationalizers as challenging interests and the community population as repressed interests. Finally and similarly, in direct reaction to the pluralist argument Bachrach and Baratz (1963) develop the notion of the "second face of power", arguing that power can be expressed in both decisions as well as non-decisions. These refer to the "... practice of limiting the scope of actual decision-making to 'safe' issues by manipulating the dominant community values, myths, and political institutions and procedures" (Bachrach and Baratz, 1963: 632). This is complemented by Lukes (1974), who introduces the concept of the "third face" of power: it "... allows for consideration of the many ways in which *potential issues* are kept out of politics, whether through the operation of social forces and institutional practices or through individuals' decisions" (Lukes, 1974: 24; emphasis in the original). This implies that there is a contradiction between the interests of those people exercising power and the 'real' interests of those who are excluded. Insofar as neo-élitist approaches focus on the structures underlying policy, they can be used to explore the power relations in health care. This appears to be particularly important in the case of nursing which is not necessarily involved in policy-making, although it assumes a central role in the provision of health care.

Health care as *institutions*

These different approaches to understanding health policy, and its underlying distribution of power, are situated at different points on the continuum between structure and agency. Harrison *et al.* (1990: 1) and Ham (1992: 224), though, question the underlying notion of the dichotomy between structure and agency: they argue that politics is the outcome of both power relationships and the structures which facilitate and constrain them. Similarly, at a more abstract level Hay (1995: 189) suggests that "... structure and agency logically entail one another - a social or political structure only exists by virtue of the constraints on, or opportunities for, agency, that it effects".

Recent years have seen more explicit attempts to combine both perspectives. Certain formulations of the "new institutionalism", for example, focus on the ways in which institutions act as opportunity *as well as* constraints structures. Furthermore, this new institutionalism is characterised by a greater interest in the state[7]. Lane (1993: 173) even goes as far as saying that the "... new institutionalism amounts to a new theory of the state ...."[8]. Its starting-point is a critique of contemporary political science, which is perceived to downgrade the state as an independent actor, explaining

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7 For a more general overview of the institutionalist approach see Rhodes (1995, 1997). But, as Rhodes (1995: 42f) argues, the institutional approach is a classic component of political enquiry. Against this background the adjective 'new' becomes questionable: "Indeed, the study of institutions could be new only to the advocates of American behaviourism or European state theory who has deliberately downgraded its importance" (Rhodes, 1995: 54). Jordan's (1990) criticism goes even further and he argues that the state-centred new institutionalism is problematic, as it lacks both a clear understanding of institutions and the state. However, in this respect Döhler (1991) stresses that while the traditional understanding of political institutions centred around formal organisations such as parties or parliament, the neo institutionalism has a much broader focus.

8 More generally, the renewed interest in institutions has to be seen in the context of the debate about the state's capability to govern: this has arisen from the euphoria about planning in the 70s, on the one hand, and the subsequent disillusionment as reflected in the debate about government/policy failure, on the other (Blanke, 1994: 14).

politics as the outcome of individual action and explaining individual actions as motivated by rational self-interest (March and Olsen, 1984: 734ff)[9].

In the context of the comparative study of health the historical variant of institutionalism is particularly popular. It defines institutions as "... the formal and informal procedures, routines, norms and conventions embedded in the organizational structure of the polity or the political economy" (Hall and Taylor, 1996: 938). Moreover, historical institutionalism is particularly sensitive to asymmetries of power associated with the operation of institutions and to "path dependencies", understood as political legacy. As such they potentially provide a basis for operationalising neo-élitist conceptualisations of health policy and are potentially particularly relevant for analysing how the institutional context of health care affects the ways in which nursing is governed in different countries.

It could be argued that institutions provide not only constraints but also opportunities, in that they demobilise some interests while they privilege others. Seen in this way, institutions represent structure and at the same time allow for agency. It is impossible, then, to separate institutions and interests: "... social outcomes depend not only upon the interests involved in confrontation and collaboration but also upon the institutions through which interaction takes place ..." (Lane, 1993: 176). However, the intermediate position of historical institutionalism on the structure-agency continuum is subject to debate. In a recent article, Hall and Taylor (1998) stress that historical-institutionalist analyses have tended to be structuralist in their nature, in that they have emphasised the importance of institutional inertia. They go

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[9] Hall and Taylor (1996) distinguish between different schools of new institutionalism: "historical institutionalism"; "rational choice" which tries to understand the operation and development of institutions using economic parameters (such as rent-seeking, property rights or transaction costs); and "sociological institutionalism" which provides a broader definition of institutions. It blurs the distinction between formal rationality (as expressed in rules, procedures and norms) and culture; culture itself becomes an institution. Similarly, Lane (1993) distinguishes between "sociological institutionalism", which corresponds to the historical institutionalism identified by Hall and Taylor, and "economic new institutionalism".

even further and argue that "... 'institutionalists' must remain structuralist at least in the sense that they seek to reveal how institutions shape social and political life" (Hall and Taylor, 1998: 959). At the same time, however, they acknowledge that historical institutionalism is potentially well placed to provide new insights into the relationship between structure and agency. Here, they point to the focus of historical institutionalism on the distribution of power (and how institutions confer powers to some actors while reducing the power of others); to its focus on the importance of ideas (in defining political issues and in providing actors with multiple options); and to its focus on the process through which actors interact to affect policies. These arguments support the plea by Hay and Wincott (1998: 957) to reformulate the "social ontology" of historical institutionalism in a way that "... structure and agency are conceived as comprising not a dualism but a complex duality linked in a creative relationship." This implies a dynamic understanding of institutions and the actors of whom they are comprised. Institutions, then, are seen to shape the interests, strategies and resources of actors, but are simultaneously also shaped (maintained or changed) by these actors.

These salient issues of structure, agency and the role of the state underlying the debate about historical institutionalism are also reflected in the more recent comparative analyses of health care[10]. Moran (1995), for example, suggests turning the study of health care upside-down: rather than analysing the role of the state in health care, he advocates studying health care as part of the portfolio of state activity. This change of perspective is reflected in his notion of the "health care state". Its three "faces" describe different dimensions of state activity. Firstly, the state is a regulator of the conditions under which health services are delivered (this includes issues of citizenship and professional power, as well as of the nature of policy outputs and effects). Secondly, health care is part of the capitalist industrial state,

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[10] A sub-set of this strand of the literature analyses the relationship between the state and the medical profession, emphasising the importance of the institutional structures doctors are embedded in (cf. Moran and Wood, 1993; Freddi and Björkman, 1989). These studies are discussed in more detail below.

where the state acts as a promoter, regulator and player, Finally, health care is part of the pluralist democratic state.

A prominent example of an institutionalist analysis is the study by Immergut (1992). In her comparison of Swiss, Swedish and French health policy she focuses on the ways in which decisions are mediated through institutions, especially the formal institutions of representative government. However, she emphasises that there "... is no direct correlation between a particular set of political institutions and a given health policy. Rather, institutions change the course of policy-making by the ways in which these rules link particular decision-makers or allow them greater or lesser independence of action" (Immergut, 1992: 27). A slightly different argument is presented by Wilsford (1994), who stresses the importance of structural forces or "path dependencies": "... actors are hemmed in by existing institutions and structures that channel them along established policy paths" (Wilsford, 1994: 251). In order to explain change, particularly of the non-incremental type, he introduces the notion of "conjunctures" "... which are the fleeting comings together of a number of diverse elements into a new, single combination" (Wilsford, 1994: 257). The notion of path dependency is echoed by the argument underlying Döhler's (1991) analysis of health policy in Britain, Germany and the United States in the 80s and the extent to which market governance was promoted by the respective governments. He maintains that the success of policy depends on the 'goodness of fit' between the reform proposals and the institutional characteristics of the health policy arena. In later articles on German health policy (Döhler, 1995, and 1992 a, b with Manow-Borgwardt) this view is modified and greater emphasis is put on the opportunities within existing institutional structures to implement incremental change ("legacy as a springboard for political action"). These arguments are closely related to the debate about the capacity of the state to govern: adopting a positive tone Döhler (1995: 380) characterises the state as an "architect of political order", "... that can create, re-arrange or even destroy established structures of interest representation".

Health care as *governance*

Parallel to the renewed interest in institutions and the state, the ways of understanding the process of governing itself have been questioned. Here, recent debates refer to "governance" which is used both as conceptual tool and as a descriptions of new forms of governing. In the context of the comparative analysis of nursing, the first usage of governance can help to widen the institutional approach, accounting for the potentially broad range of institutions, actors and particularly levels governing nursing.

Traditionally, governing has been defined as state activity, typically taking the form of regulation. It places constraints, that is rules, on the exercise of discretion by those with market or institutional power (Dyson, 1992: 1). Regulation, then, concerns the exercise and control of power, and as such, it reflects the role of the state in society and the economy. At the same time, the role of the state in regulatory arrangements varies and Webber (1992b: 210) identifies three core modes of regulation, notably market regulation, state regulation and collective self-regulation[11].

In contrast, more recent debates advocate adopting a broader approach, described as "governance". It emphasises the complexity and the co-operative nature of the process of governing and thereby also questions the role of the state in governing. It is based on the argument that the one-sided control or action by the state is only one of the layers of governing (Blanke, 1994: 13ff; Kooiman, 1993): "The governance concept points to the creation of a structure or an order which cannot be externally imposed but is the result of the interaction of a multiplicity of governing and each other influencing actors ..." (Kooiman and van Vliet, 1993: 64, as quoted in Blanke, 1994: 14). Similarly, Dunsire (1993: 22) defines governance very broadly, as "... the

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[11] Similarly, Moran and Wood (1993: 17) distinguish between different ways of organising regulation: independent self-regulation, state-sanctioned self-regulation and direct state regulation.

arrangements societies make to keep disturbances within bounds and to steer change away from undesired and towards desired directions ...". More specifically, Rhodes (1997) points to the wide range of meanings of the concept of governance. By way of synthesis he suggests the following definition (1997: 53): governance means interdependence between organisations. Thus, the process of governing goes beyond government and also includes non-state actors. There is continuing interaction between actors within networks which follow specific rules of the game, negotiated and agreed by the network participants. At the same time, these networks of actors have considerable autonomy from the state in that they are self-organising. In his specific study of British government, Rhodes (1997) also argues that the concept of governance helps to understand the altered nature of government. In the case of Britain he stresses that the Conservative reforms of the 1980s and 1990s "... deliberately fragmented service delivery systems, generating functional imperatives for inter-organizational co-ordination". Thus, "... the centre's capacity to regulate them remains underdeveloped" (Rhodes, 1997: 56).

Implications for the analysis

While the preceding sections have reviewed different ways of understanding health care from a comparative perspective, the conclusions discuss how these can complement an inductive, actor-centred analysis of nursing. It is suggested that the institutionalist approach, combined with governance as a conceptual tool, appears to be particularly useful.

Considering that nursing seems to be at the margins of the health policy agenda, structuralist perspectives with their focus on power relations can provide a lever for the comparative analysis of nursing. The nature and manifestations of power can be further explored by using an institutionalist analysis. Here, Hall and Taylor (1996: 941) stress that "All institutional studies have a direct bearing on power relations. Indeed they can usefully be read as an effort to elucidate the 'second' and 'third' dimensions of power identified some years ago in the community power debate".

This means analysing how the institutions of health care affect the ways in which nursing as an occupation is governed, and more specifically, how they act as constraints and opportunity structures vis-à-vis nursing. Here, the concept of governance can help to exploit more fully the potential of the institutionalist approach. It can widen the perspective as it stresses the complexity of the process of governing which is reflected in the potentially multiple arenas, levels and actors of policy-making. Thus, the concept of governance may help to account for the fact that nursing does not necessarily fit into a top-down understanding of health care.

3 Framework of the analysis

Reviewing the relevant social sciences literature, chapters 1 and 2 discussed how theories of professions and the comparative literature on health care can contribute to analysing the occupational governance of nursing in a comparative context. This chapter begins by summarising the arguments presented so far and it then outlines the framework of the analysis. It suggests adopting a multi-level approach by combining the analysis of occupations with an institutionalist study of health care[1].

The review of theories of professions argued in favour of turning them upside-down and for adopting an inductive, actor-centred approach. As the concept of professions tends to constrain the study of nursing and the comparative approach, it becomes the subject of the enquiry itself. Thus, throughout the study the less value-laden term of occupation is used. Furthermore, it was argued that the inductive understanding of occupations can be operationalised by adopting an actor-centred perspective. This requires analysing the actors involved in the occupational governance of nursing, their interests, strategies and the relationships between them. The suggested approach puts nursing at the centre of the analysis and is also considered to be flexible enough to account for the possible variation between countries. The comparative analysis of occupations can be further strengthened by examining the health systems in which nursing operates in different countries. This involves adopting a multi-level approach.

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[1] There are examples of comparative studies which use a multi-level approach, although their starting-points vary. Haug (1995), for example, uses a micro-study of the division of labour between nurses and doctors in British and German hospitals to further explore (macro-) statistical observations about the significantly different doctor-nurse-ratios in both countries. In contrast, the primary aim of the comparative studies of social work by Cooper *et al.* (1995) and Hetherington *et al.* (1997) is to understand occupational practices of child protection. Here, the macro level is used to contextualise data collected at practitioner level. The approach taken by the present study is somewhere in-between: it starts off with a macro-analysis and the issues identified here are further explored as part of a micro-case study. At the same time, it is acknowledged that the micro level is an integral part of understanding occupational governance.

Against this background, different ways of understanding health care comparatively were explored and an argument was made for combining an institutionalist approach with the concept of governance. Institutions serve to describe as well as to explain systems of health care and they represent the context in which actors operate. As such, the institutionalist perspective provides a lever for analysing nursing in different countries and for exploring how its governance is influenced by health systems. Also, it offers a way of operationalising neo-élitist explanations of policy, which focus on the power relations underlying health care. The concept of governance helps to widen the institutionalist perspective as it can account for the complexity of governing.

In summary, the 'review of the reviews' suggests adopting a multi-level approach, by combining an actor-centred analysis of occupations with an institutionalist study of health care. These two perspectives complement each other: while the former focuses on the actors governing nursing, the latter provides a basis for exploring the institutions of health care in which they operate. This is particularly relevant from a comparative perspective, as institutional contexts are likely to vary between countries. Similarly, whereas the sociological study of occupations can be used to analyse the micro level of work and work organisation[2], the political science perspective of health care tends to be concerned with the characteristics and operations of entire health systems, focusing on the macro level. Combining different levels of analysis seems to be particularly important in the context of nursing: although it may be primarily visible at the level of practice, nursing is likely to be affected by the macro-institutions of health care.

Thus, the occupational governance of nursing can be defined as the ways in which nursing is governed by institutions and actors, across different levels. In the context

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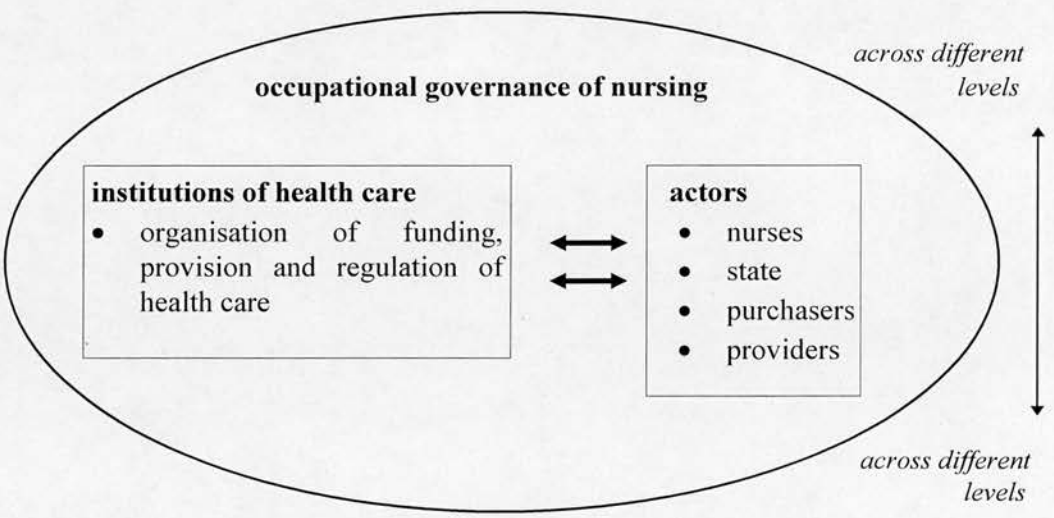
[2] But that does not necessarily mean that it is confined to micro-analysis. Instead, theories of professions have frequently been used to analyse macro aspects of the organisation of work, such as the collective organisation of occupations in interest groups or self-regulatory bodies, or the institutionalisation of knowledge through education.

of the analytical framework, institutions are defined as "... the formal and informal procedures, routines, norms and conventions embedded in the organizational structure of the polity or the political economy" (Hall and Taylor, 1996: 938). More specifically, the institutions of health care reflect the ways in which the funding, provision and regulation of health care are organised. Considering the multi-level approach of the study, the framework of the analysis considers a broad range of actors: nurses, individually as practitioners or teams and collectively as interest organisations or self-regulatory bodies; the state, notably government ministries and agencies; purchasers as the financiers of health care; and providers, as the employers of nurses and/or as fellow practitioners (as in the case of doctors practising in primary care). The analytical framework can be summarised as follows:

Figure 3.1 Framework of the analysis



The discussion so far has focused on conceptual issues: how to analyse the occupational governance of nursing from a comparative perspective. But little has been said about *what* is governed. The 'substance' of the occupational governance of nursing can be operationalised by examining different dimensions or areas of governing. These represent the categories of the analysis. Following the review of theories of professions, it could be argued that while defining occupations is

problematic from an analytical perspective, it may be a central aspect of the *practice* of governing occupations. In conjunction with the review of the comparative literature on health care, this leads to three initial dimensions of occupational governance: the division of labour in health care, nursing education and organised interests in nursing. Firstly, nursing can be defined through the division of labour, both with respect to other occupations and between different subgroups in nursing. Secondly, education provides another approach to definition, in that training in certain skills represents an ideal-typical formulation of the scope of nurses' practice. Finally, definitions of nursing are shaped by the ways in which nurses' interests are organised and the role they play in health policy. The suggested connection between the theory and practice of the occupational governance of nursing is discussed in more detail in the chapters on methodology. Together with the macro-analysis of occupational governance they also outline how these categories were generated and why they are significant[3]. But governance is also influenced by the wider dynamics of health care that is: the dual challenge of meeting potentially increasing demands in a climate of cost efficiency/containment. These put existing institutional arrangements under stress and they also have an impact on the agenda of the actors involved in the governance of nursing.

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[3] See chapters 7-10 and chapter 6 respectively.

METHODOLOGY

While chapters 1 to 3 were concerned with the framework for analysing the occupational governance of nursing from a comparative perspective, the following set of chapters (4-6) focuses on the research process itself. It aims to account for what was done, how it was done and why it was done in this way rather than another. Thus, methodological issues are identified at each stage of the research and are discussed against the background of the review of the literature. Methodology is determined by the theories used, the research question and the area of study generally. However, rather than being fixed from the outset, methodological decisions evolve alongside the research and are also influenced by the practicalities of the research. While this last point is not meant to justify 'convenience methodology', it highlights the need to adjust methods to the research setting, as well as to other constraints. Thus, particular attention is paid to the interplay between theoretical and practical considerations in the continuous *process* of methodological decision-making.

The structure of the chapters follows the course of the research process. However, this is complicated by the fact that the research consisted of two parts. After a set of literature reviews the first stage of the empirical research adopted a macro-perspective and looked at different dimensions of the occupational governance of nursing in Britain and Germany. In contrast, the second stage consisted of a micro-case study, which analysed the governance of internal boundaries in community nursing. Although both parts are closely related to each other, and use similar research methods, the specific challenges and questions they raise in methodological terms differ in some respects.

The methodological discussion begins by outlining the central strategies of the research (chapter 4). While the comparative method is a constant theme throughout the research, the case study is restricted to the second part. The research methods

themselves are examined in chapter 5. They comprise the analysis of primary material, semi-structured interviews and focus groups. While the first two were employed in both parts of the research, focus groups were exclusively used in the context of the case study. Finally, chapter 6 outlines the analysis of the data. It begins by discussing the research approach underpinning the study. Subsequently, a description is offered how the categories to order the data were developed, and how the data was subsequently interpreted. Here, particular attention is paid to the issues of validity, reliability and generalisability.

4 Research strategies

This chapter is concerned with the central research strategies of the study. These are a comparative and a case study approach: the research is a comparative study of the occupational governance of nursing in Britain and Germany and also includes a case study of the governance of internal boundaries in community nursing. Interestingly, there is some debate about the relationship between comparison and case studies. Satori (1994: 23ff), for example, argues that, in principle, comparison and the case study represent two alternative research strategies: while the case study focuses on individualising, comparison is concerned with generalising. Similarly, Stake (1994: 242) emphasises that comparison is "... an epistemological function competing with learning about and from a particular case". In contrast, Ragin (1987) stresses the close connection between the two, in that comparative research has traditionally been case, as opposed to variable-oriented. The research is based on the assumption that the comparative and the case study approach are compatible: the case study is used to illustrate the issues identified as part of the (macro-) analysis of the different dimensions of the occupational governance of nursing. The special challenges arising from this, notably in terms of generalisability, are discussed in chapter 6 which deals with data analysis.

Comparison

The research focuses on comparison between countries and the comparative research strategy is discussed by addressing the following issues: the reasons for comparison (why?), the scope of comparison (comparing what?) and the specific challenges of the comparative approach. In contrast, the process of comparison (comparing how?) is dealt with in more detail in chapter 6. While some of these issues are specific to cross-country comparison, others apply to comparison more generally. This reflects the fact that "... in many respects, the methodology adopted in cross-national

comparative research is no different from that used for within-nation comparisons or for other areas of sociological research" (Hantrais and Mangen, 1996b: 5f).

In the literature the following reasons are identified for doing comparison[1]: at a general level, first, it is simply interesting to explore other countries ('academic tourism'). Moreover, structured comparison provides a framework for determining those features which are due to unique circumstances and those which are more generally applicable (Antal *et al.*, 1987: 14). At the same time, the initial exploration of other countries also asks for further analysis. Secondly, one method of trying to understand differences and similarities between countries is to evaluate them, that is to assess the performance of specific structures against a set of criteria. Frequently, the underlying aim is to learn lessons from other countries and to identify 'best practices', which can inform the policy development of one's own country. A third approach is explanation. This means accounting for the differences and similarities between countries, by testing or formulating hypotheses. In this respect the comparative enquiry also provides the basis for theory building, in that it helps to identify systematic patterns and relationships (Øyen, 1990b: 3).

In the context of the present research, exploration and explanation were the most important reasons for adopting a comparative approach[2]: there is relatively little research which looks at nursing in different countries. A possible explanation is that nursing is still largely the domain of nursing studies, which is concerned with 'research for nursing', as opposed to 'of nursing'. While there has been some 'transatlantic diffusion' of nursing models and theories from the United States to

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1 For an overview of the comparative method see Antal *et al.* (1987), Feldman (1978), Hantrais and Mangen (1996a), Lane and Errson (1994), Mackie and Marsh (1995), Øyen (1990a), Ragin (1987), Roberts (1978), Satori (1994), and Schmidt (1988).

2 In contrast, using comparison as a framework for evaluation was not relevant in the context of the research. This is reflected in the thrust of the research questions, which are primarily concerned with exploration and explanation.

Britain, and from the United States and Britain to Germany[3], the comparative analysis of organisational/occupational features of nursing in different countries is hardly addressed. This is exacerbated by the fact that nursing tends to be neglected in the mainstream social sciences, where comparison assumes a more prominent role[4]. Against this background, comparison was employed to explore the occupational governance of nursing in Britain and Germany. At the same time, the comparative approach provided a basis for explanation, by assessing the importance and role of different institutional settings[5].

In the context of the study the explanation of differences was particularly important. This reflected the choice of countries, which follows the "comparable cases strategy" (Lijphart, 1975). Here, the cases "... are similar enough in a large number of important characteristics, but dissimilar with regard to the variables between which a relationship is hypothesized ..." (Lijphart, 1975: 159)[6]. This approach is particularly appropriate "... where the problem is one of identifying and accounting for specific differences ..." (Roberts, 1978: 293). In the context of the research, Britain and Germany share high levels of wealth (as opposed to 'developing' countries) and the notion of public involvement in welfare. At the same time, the ways in which health care is organised, provided and financed show interesting differences, which can be

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3 Nursing as an academic discipline was first established in the United States. The emerging body of nursing theories and models became increasingly popular within British nursing, especially when the first Departments of Nursing Studies were established from the late 1950s onwards. This diffusion of knowledge was not only helped by a common language, but also historical commonalties, notably the minor role played by lay or religious nursing orders. In contrast, these have traditionally been very strong in Germany and it is only since the 1960s that nursing has become more secularised. This historical isolation might explain why nursing is only now being established as an academic discipline and why American and British nursing theories and models have been an important point of reference for German nursing. Meanwhile, however, the situation in Britain as well as in Germany is beginning to change and there is an increasing number of 'domestic' textbooks.

4 For a more detailed discussion see the literature reviews in chapters 1 and 2.

5 For a discussion of the ways in which the institutions of health care can help to explain the features of the occupational governance of nursing cf. chapter 11.

6 The underlying aim is to reduce the overdetermination of cases ("many variables, small N"), that is the fact that the number of possible variables by far exceeds the number of cases.

summarised in the ideal typical distinction between national health service and social insurance system. As discussed earlier the underlying assumption was that the governance of nursing is influenced by these institutional frameworks and, therefore, differences were expected to be particularly prominent.

The question regarding the scope of comparison concerns the object of comparison, which can be nations, societies, cultures or policies. In the context of the research the object of comparison is manifold. At a general level, the research is a comparison of two countries, notably Britain and Germany. While the preceding paragraph argued that these countries are chosen because of their explanatory potential, there are additional, more practical, reasons. These are related to what Feldman (1978) calls "essential competence", which he considers an important prerequisite for doing comparative research. A central challenge of any comparison is to cover a considerable amount of material within a limited period of time. Against this background it is important to build on existing expertise; in my case, that is, earlier work on health policy-making in Britain and Germany. Furthermore, as a result of the shortcomings of the literature, native sources were vital and a knowledge of the respective language was essential. Finally, the research questions require the collection and analysis of qualitative data. The access to participants as well as the collection of the data is facilitated by not having to rely on intermediaries such as interpreters and translators. In summary, then, in the context of the research the choice was restricted to English or German-speaking countries. Within the overall framework of cross-country comparison, the study also compared and contrasted the actors and institutions governing nursing.

The challenges of cross-country comparison primarily arise from having to bridge different cultural contexts and from having to operate between different languages. More specifically, there is the problem of definition, as the meaning of concepts

differs between countries[7]. Whilst one of the aims of comparison is to explore this variation, this requires a common analytical framework. In the context of the research, for example, the concept of professions posed considerable problems of definition: the literature suggests that its meaning is closely intertwined with the specific Anglo-American context (cf. McClelland, 1990)[8]. Interestingly, there is no direct German translation which conveys the same meaning. Against this background the more general, and less culturally-bound, term "occupation" is used throughout the study. In addition, it is defined in broad terms, notably as the occupational governance of nursing and its key dimensions[9]. Another challenge arises from the need to operate between two languages and to translate constantly from one to the other. But when "... accounts are translated into different languages it may be necessary to try to convey meaning using words other than literally translated equivalents" (Temple, 1997: 610). In the context of Germany, for example, the analysis refers to doctors working outside hospitals as "office-based doctors". This stresses that their role in the provision of health care is quite different from that of British GPs. The specific terms used in the analysis of the German case and the comparative analysis more generally, are listed in the glossary at the beginning.

Case Study

In general terms case studies are defined as research which is interested in individual cases, understood as "bounded systems" (Smith, 1978 as quoted in Stake, 1994: 236). There is some debate about the reasons for conducting case studies: from the perspective of the positivist research paradigm case studies are regarded as exploratory, identifying issues for subsequent quantitative analysis (Stoecker, 1991: 90f). In contrast, Yin (1989: 16ff) suggests classifying research strategies according

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7 This corresponds to what Vijvier and Leung (1997:11) call "construct bias", that is the "... incomplete overlap of definitions of the construct across cultures ...".

8 For a more detailed discussion see the review of theories of professions in chapter 1.

9 Following such a "de-centred" approach (Vijvier and Leung, 1997: 13) means to take into account culturally diverse perspectives when conceptualising and designing a study.

to different types of research questions and argues that case studies are most suitable for 'how' and 'why' questions. Thus, they can be exploratory, descriptive as well as explanatory in their nature. A slightly different typology is offered by Stake (1994: 237f) who distinguishes between intrinsic case studies, where the case itself is of interest and where the purpose is to better understand a particular case, and the instrumental case study, where the case plays a supportive role and serves to further the understanding of a theory or a more general issue[10]. The reasons for conducting case studies, then, vary and Hakim (1987: 61) suggests that case studies are the most flexible of all research designs. However, case studies, of whatever type, share the basic assumption that one can learn from studying a particular case and "... case researchers seek out both what is common and what is particular about a case ..." (Stake, 1994: 238). This implies that the case study is an expression of totality and that understanding the relationships in part facilitates understanding the whole (Stoecker, 1991: 105). The tension between the uniqueness and the generalisability of a case is particularly important when analysing data, but it is also relevant when initially selecting a case, particularly if its purpose is instrumental (Stake, 1994: 243). Consequently, the selection of a case is of central importance. It can be understood as a process of sampling, in that the case is supposed to represent a phenomenon more generally. However, to choose a case from which one can learn most does not mean mimicking representativeness but making a theoretically-informed choice. In addition, Stake (1994: 244) identifies a second round of sampling, notably sampling within a case. Here, important criteria are variety (as opposed to representativeness), as well as considerations of access and "hospitality", that is the willingness or even enthusiasm on the part of the 'case' to be studied.

In the context of this research the purpose of the case study was instrumental and was closely connected to the first part of this study, which focuses on different dimensions of the governance of nursing in Britain and Germany. Although the

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[10] Similarly, Stoecker (1991: 100) distinguishes between case studies which focus on explaining the case, and those which focus on elaborating theory.

initial analysis of primary and secondary sources was complemented by élite interviews, the data gathered tended to be non-specific in its nature. At the same time, it emerged from the research that micro-politics play an important role in the occupational governance of nursing. Against this background, a more specific perspective was adopted in the second part of the research, in terms of both the area of study and the locality. The purpose of the case study, then, was to illustrate central issues of the occupational governance of nursing in Britain and Germany. Here, the governance of internal boundaries, that is the interface between staff with different levels of qualification, seemed to be particularly interesting, both for theoretical and empirical reasons. Internal boundaries define what an occupation is, and what it does, and as such they are central for understanding the governance of nursing. At the same time, the governance of internal boundaries has been politicised by current developments in health care and community care, in particular, which provide an interesting framework for analysis.

The focus of the case study on how decisions about internal boundaries are made and who is involved meant concentrating on specific locales. While both the case study as well as the first part of the research were interested in Britain and Germany, as such, for practical reasons the respective empirical research focused on Scotland and North Rhine-Westfalia. Such an approach rests on the assumption that there are unlikely to be significant differences between Britain and Scotland, and Germany and North Rhine-Westfalia, respectively in terms of the governance of nursing and the institutional framework of health care settings. However, this is not to deny specific organisational features or cultural/policy orientations. In the context of Britain, Parry (1998: 191) notes that "The United Kingdom is a strongly unitary state and lacks a clear concept of regional differences in social policy in terms of formation, implementation and content". Similarly, in the case of Germany while the health governance is fragmented along different horizontal and vertical layers of decision-making, state governments have little influence except in the area of hospital planning. Against this background, the analysis in chapters 7 following only generally refers to the "British" and the "German" case.

Considering time and resource constraints it did not seem feasible to include more than one locale in each country. More importantly, focusing on only two provider units also offered the opportunity for an in-depth study. This seemed to be particularly important considering that the case study was interested in the detailed process of governing internal boundaries at the level of the local provider and within the community nursing teams. Another consideration was choosing broadly comparable locales, in terms of both type of provider and geographical location[11]. The notion of comparability, however, is not treated as a weak form of representativeness. Instead, it represents the attempt to mediate between the need to choose localities which are similar enough to be compared ("comparing like with like") and the fact there is no exceptionally typical locality ("all localities are exceptional"). In Scotland geographical variation is particularly extreme, notably the contrast between locales in the Central Belt and those in rural areas of the Highlands & Islands, the Borders and south-west Scotland, while trusts are the predominant type of provider. Conversely, in North Rhine-Westfalia, as the state with one of the highest population densities, geographical variation is less pronounced. Instead, contrasts between different types of providers, that is private vs. non-profit, are more important. But more importantly, in the context of the study of the governance of internal boundaries urban localities appeared to be more appropriate. They were more likely to be larger organisational units, with a reasonable number and diversity of staff, and with a complex division of labour between staff with different levels of training. In turn, this provided an ideal context for studying decisions about internal boundaries. Furthermore, the non-profit providers in Germany appeared to be most comparable with Scottish trusts[12].

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[11] Issues of comparability are addressed in more detail when discussing the choice of interviewees in chapter 5 on research methods. The institutional characteristics of the provision of community care are dealt with more thoroughly in chapter 12, as part of the introduction of the case study.

[12] The underlying argument is two-fold: the non-profit orientation of these providers is comparable to the public environment in which the NHS trusts are embedded. Further, while the range of services of individual providers is limited, their membership in the respective umbrella organisation at local level de facto means that they are part of a much wider and more diverse service structure. At the same time this also helped to neutralise the difference in size:

Subsequently, possible locales were discussed with informants, in the hope that they might assist with getting access to the locale[13]. In the case of North Rhine-Westfalia access was hardly a problem: due to his work as a researcher for the local authority, the informant had well established contacts with local providers. At the same time the local provider also expressed strong interest in the research. In contrast, in Scotland access was much more difficult. On the one hand the Central Belt is a heavily researched area and there is considerable competition in getting access to trusts, but on the other hand, the management of the two trusts which were approached also appeared to be genuinely sceptical about the research project. The arguments ranged from concerns about the extra time commitments the research would put on district nurses, to the fact that the decision about taking part in the research would be in the hands of lower tiers of management and the district nursing teams themselves. However, to some extent these points appeared to be a pretext for the more general uneasiness about district nurses being part of the study: the nurse manager of one trust, for example, emphasised that access would be no problem, if the research were restricted to managers. Here, the process of getting access was also highly formalised, in that the research proposal had to be formally submitted to a regular meeting of senior nurse/locality managers. In the other trust, which finally agreed to take part in the study, the initial reaction was openly hostile: a meeting to discuss the research proposal started with the nurse manager saying that she saw hardly any chance of the research going ahead. In the course of the discussion she also argued that the district nurses themselves might be reluctant, as they might see little point in the research. In contrast, at a later date, the district nursing teams stressed that they had had little or no briefing from the nurse manager and that she was very good at "making you do things". While these experiences may reflect personal styles, they may also point to the adversarial culture of the internal market

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whereas the Scottish trust consisted of two localities with several district nursing teams each, the provider in Germany only had three community nursing teams. For the same reason, the research was restricted to one locality of the trust in Scotland.

13 A profile of the two local providers in which the fieldwork was conducted is included at the end of chapter 12.

and the anxiety about 'whistle blowers'. However, whereas these cultural differences were reflected in the interview data, they did not necessarily affect the 'quality' of the data.

5 Research methods

While chapter 4 discussed comparison and the case study approach as the two central strategies of the research, this chapter turns to the research methods themselves. These consist of the analysis of primary material, interviews and focus groups. Having discussed comparison as a research strategy, this chapter (and the following) is concerned with 'comparison in practice', that is how the comparative research was conducted and what the specific challenges were[1].

Analysis of primary material

Primary material is part of the wider "material culture" and is designed especially to be communicative and representational (Hodder, 1994: 395). While primary material is produced 'in action', that is as part of the social process/phenomena in question, secondary literature reflects on it in an academic context (Reh, 1995: 204). Primary material can take many forms, such as government legislation, policy statements of health board, articles in professional journals or statistics. The distinction between primary material and secondary literature to some extent depends on the research question, but gives a broad indication of the context in which a text has been produced. This is central for understanding texts (Hodder, 1994: 394; similarly Schmid, 1995: 306).

As the research 'for nursing' is much stronger than that 'on nursing', primary material was used from early on in the research: this included professional nursing journals, nursing textbooks, monographs in nursing studies and statistics on health care services. The material was identified by searching library catalogues, especially of the National Library of Scotland and the *Zentralbibliothek der Medizin*, which is a specialist library for medical and health care literature. This was complemented by a

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[1] These will also be discussed as part of the empirical analysis in chapter 7 following.

search of databases, such as the International Nursing Index. The use of primary material considerably increased in the second part of the study, where highly specific information was required, such as on the community care strategy of the health board or policy statements of the provider organisation in Germany. The purpose of the analysis of primary material, therefore, was two-fold. Firstly, it provided a central source of information. Moreover, it was instrumental when redefining the research question and formulating an initial set of categories for the data analysis[2].

In terms of the analysis itself, Reh (1995: 216) distinguishes between linguistic analysis and the analysis of the substance of a primary material. The second type of analysis includes summarising sources, exploring explanations by consulting other sources and 'dissecting' sources according to the underlying research question. The research focused on this type of analysis. Primary material was searched for and collected together with the secondary literature. The search was guided by the different stages of the development of analytical categories discussed in chapter 6 which deals with data analysis. Here, a particular challenge was to identify 'comparable' literature. In the context of the literature on management, for example, the British sources tended to be concerned with the changes in the structure of health care management in the NHS and its impact on nursing. The German literature, by contrast, paid more attention to the operation of management at the micro level of local provider units. But at the same time, both bodies of literature had some salient issues in common, such as the role of nurses in management, especially compared to those of doctors and general administrators. The material gathered in the two rounds was summarised and analysed in the form of discussion papers. Moreover, to ensure that the material could also be used beyond the stage of the research at which it was collected, the primary material, together with the secondary literature, was summarised in 'annotated bibliographies'. These proved to be very helpful for clarifying points at later stages of the research. In the context of the case study the

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[2] The last aspect is addressed in more detail in chapter 6 on data analysis.

analysis of literary material was complemented by an analysis of the relevant statistical material. The underlying aim was to explore the 'bigger picture' of nursing in each country. Furthermore, the basic analysis of statistical material posed interesting questions in relation to the research. It suggested, for example, that the percentage of nursing staff with a qualification was much higher in the British than in the German case. This raised questions about how these very different grade-mixes influence not only decisions about filling a vacancy, but also the allocation of work in the teams. But at the same time, it also became clear that these questions could not necessarily be answered by analysing statistics. Furthermore, particularly in the case of Germany the range of figures available were rather limited. Thus, the analysis of statistics also implicitly supported the use of qualitative methods.

Interviews

Besides the analysis of primary material, interviews were the other key research method in both parts of the study. Here, the reasons for conducting interviews are explored; subsequently, the rationale behind the selection of interviewees is discussed; and finally, the way in which the interviews were conducted is outlined.

Although interviews were conducted in both parts of the research, their exact purpose differed. In the initial study of the different dimensions of the occupational governance of nursing in Britain and Germany, the purpose of the interviews was complementary. They served to gather additional information and to clarify and validate the insights gained from the review of secondary literature and primary material. "They (élite interviews) can help you to understand the context, set the tone, or establish the atmosphere, or the area you are researching" (Richards, 1996: 200). In the case of Germany, for example, the interviews helped to get a better sense of the impact of the long-term care insurance on the provision of community care. Furthermore, they also provided a basis for the subsequent identification of a 'case issue'. In contrast, in the context of the case study secondary literature and primary material only prepared the ground and the interviews themselves assumed a central

role in understanding the case. But regardless of these differences in purpose the interviews in both parts of the research aimed at exploring the perceptions and opinions of the respondents regarding complex and sometimes sensitive issues. Against this background semi-structured interviews appeared to be most appropriate (Barribal and While, 1994: 330; Fontana and Frey, 1994, 365; Schmid, 1995: 308). Thus, in preparation for the interviews, schedules were drawn up. They consisted of about four key issues and a number of more detailed questions for probing[3].

As a result of the different foci of the two parts of the research the process of selecting interviewees varied. The first part aimed at exploring the views of respondents regarding different dimensions of the governance of nursing in Britain and Germany, especially against the background of the challenges with which nursing is confronted. As this covers a wide range of issues (from management and education to the division of labour in health care and the organisation of nurses' interests) the focus of the interviews was likely to be non-specific; they seemed to require interviewees with a broad expertise in the field. This was likely to be the case with members of the nursing élite: as a result of their privileged position in terms of (political) influence, they tend to have a broad overview of issues and debates within their area. In the context of the research, their 'personal views as experts' were of particular interest[4]. The study focused on an élite as it seemed to provide the richest source of information, while it was not interested in the élite as such.

Schmid (1995: 314f) suggests selecting interviewees on the basis of the "snow-ball principle", as it cross-cuts other, more narrowly-focused, selection techniques and potentially also avoids their pitfalls[5]. Beyond that, the experience of contacting

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3 For more details see the discussion of interview schedules later in this chapter.

4 Following Richards (1996: 199) an élite can be defined as a group of individuals who have a privileged position in society, and who have considerable influence on political outcomes.

5 These are: selection based on reputation (but reputation may have little to do with influence); selection based on decision (but it is difficult to clearly identify areas of decision-making); and selection based on formal position (but influence may not be reflected in a formal position).

interviewees also suggests that this approach facilitates access to interviewees, as the request for an interview can be supported by a personal recommendation. Similarly, it helped to validate the selection of interviewees, in that the majority of interviewees were recommended by more than one person. Initial contacts were made using a range of strategies: in the case of Scotland, contacts from academics at the university, dating from previous research, were used. These included two civil servants from the Scottish Office and a senior nurse manager. In contrast, in the German case the names of potential interviewees were obtained from specialist directories and contact was made without prior recommendation or introduction. While the snowball principle concerns the selection of individuals, the more general selection of areas of expertise followed the principle of maximising variety[6]. Interviewees came from different types of agencies, ranging from purchaser and provider units, to government ministries and interest groups. Also, interviewees had expertise in different sectors of health care provisions, that is hospital and community care. For the same reasons as discussed above, in the context of the case study, the interviews were confined to Scotland and North Rhine-Westfalia respectively. Initial contacts were made by phone, and most potential interviewees agreed (or declined) at this stage. Foddy (1993: 70) suggests giving as much contextual information about the research as possible to prevent misunderstandings. Thus, the subsequent letter not only confirmed the date of the interview, but also included an outline of the research as well as a list of the issues which would be raised in the interview. Interviews were conducted with the following experts:

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[6] This broadly corresponds to what Morse (1994: 229) calls "extreme case sampling", where the aim is to maximise the factors of interest, in order to clarify aspects of importance.

Figure 5.1 **The occupational governance of nursing; list of expert interviews**

	government	purchasers	providers	education	organised interests
Scotland	Scottish Office 3 nursing officers	Health Boards chief nursing adviser/ director of planning and development nursing and quality adviser	trusts director of nursing and quality (hospital) director clinical services (hospital) director of nursing/ general manager (community care) GP (ambulatory care)	officer of National Board for Scotland	officer of UNISON officer of Royal College of Nursing officer of British Medical Association
North Rhine-Westfalia	State Ministry for Labour, Health and Social Affairs *(Ministerium für Arbeit, Gesundheit und Soziales)* officer for nursing	health and long-term care insurance funds *(Kranken- und Pflegekassen)* officer for long-term care officer for contracts and hospitals nursing officer of medical advice service of the insurance funds	hospitals and community care providers director of nursing services *(Pflegedienstleiter)* (hospital) medical director *(Ärztlicher Leiter)* (hospital) officer of umbrella organisation of providers (community care)	professor of nursing studies	officer of trade union *(Gewerkschaft für, Öffentliche Dienste, Transport und Verkehr, ÖTV)* officer of professional organisation *(Allgemeine Deutsche Schwesternschaft, ADS)*

In contrast, the case study was concerned with decision-making within two localities. Consequently, the selection of interviewees was more restricted and confined to those actors who were involved in the governance of internal boundaries. Whilst this was part of the research question, it was possible to make informed guesses with respect to selection from secondary literature and primary material, as well as from the élite interviews. In addition, the issue was also raised with the local provider as part of the initial discussion regarding the practicalities of the research. Again, a central concern was to ensure the comparability of the British and German data. The identification of 'functionally equivalent' interviewees was facilitated by schematic overviews of the decision-making structures[7].

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[7] See figures 12.2 and 12.3 at the end of chapter 12.

Figure 5.2 The governance of internal boundaries in community nursing; list of interviewees

In the Scottish case the research focused on one of the two localities of a trust, and interviews were conducted

- with the operational management of the locality, that is the locality manager and the nurse manager. Interestingly, both argued that apart from situations of conflict the nursing director has little if any role in operational decisions about district nursing. While it seemed inappropriate to interview her 'behind their backs', the issue of her position was raised in the interviews with the locality and the nurse manager.
- with a member of the core group of the GP consortium and the senior partners of the practices to which the two district nursing teams, included in the study, were attached. GPs assumed a central role, notably as the convenors of primary health care teams and as the purchasers of district nursing services. In contrast, the health board appeared to be rather remote from local decision-making, as its role was largely confined to setting the wider policy framework and to allocating funds to the consortium. Thus, the material gathered on the polices and strategic plans of the health board seemed to be sufficient.
- with an operations manager of the local Social Work Department. While the Social Work Department is not directly involved in personnel issues, decisions about grade-mix and the division of labour in district nursing teams are indirectly influenced by the boundary between health and social care.

In the case of North Rhine-Westfalia interviews were conducted

- with the senior manager (*Gesamtleiter)* of the local provider and the team leaders (*Einsatzleitungen)* of the two community nursing teams included in the study. Compared to the Scottish counterpart the management hierarchy of the provider in Germany is flatter. The leaders of the community nursing teams assume an intermediary position, in that they are both managers as well as practitioners.
- with an officer of the respective umbrella organisation at state level. While the local provider is independent, particularly in financial terms, it is the umbrella organisation at state level which negotiates basic contracts and fees.
- with an officer of an insurance fund at state level. Here, the type of insurance was of secondary importance, as insurance funds largely provide the same range of care and they even co-operate in the area of long-term care.
- with a senior nursing officer of the medical advice service of the insurance funds (*Medizinischer Dienst der Krankenkassen)* at state level. The medical advice service assumes a potentially important role in quality assurance of community care services, which includes the issues of grade-mix and division of labour. In contrast, office-based doctors (*niedergelassene Ärzte)* were not included. Apart from their influence on the scope of community nurses' practice, they are remote in organisational terms and are not involved in decisions about grade-mix and the division of labour.

In terms of conducting semi-structured interviews, one of the central challenges is to strike a balance between flexibility and consistency, that is between the accounts of individual interviewees and, importantly for the subsequent analysis, the comparability of different accounts (Foddy, 1993: 17). These challenges are exacerbated by the comparative approach, as accounts have to be comparable across different countries. However, the interview schedules which were based on the key dimensions of the occupational governance of nursing provided a common framework. They are discussed later in this chapter. In the context of the élite interviews an additional problem arose from the fact that individual interviews could only cover part of the wide range of issues which were addressed in this part of the research. But as the expertise of the respondents tended to be broad, the same issues could be raised in different interviews.

The interviews themselves lasted between 40 minutes and one hour and began with a brief discussion of the issue of confidentiality. This primarily concerned the recording of the interview and the subsequent handling of the data. Audio-taping, as opposed to note taking, appeared to be most appropriate: it facilitated the later analysis and helped to promote the dynamic nature of interviewing, as well as dealt with the subtle problems of topic control (Barribal and While, 1994: 333). At the same time, the issues raised in the interviews did not seem too sensitive to outweigh the advantages of audio-taping (Schmid, 1995: 317)[8]. Furthermore, the interviewees were assured that they would be sent written summaries for comments and amendments[9]. However, the interviews were potentially 'sensitive', as élites by their very nature are small, and their members tend to know each other. This raises interesting questions in terms of anonymity: it could be argued that ensuring anonymity is impossible as well as unnecessary, because the interviewees know each

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8 However, there were a couple of situations, when interviewees made more blunt statements after the tape recorder was switched off. While these are not part of the authorised summaries, they indirectly informed the analysis, and are, therefore, not lost.

9 The decision to produce written summaries rather than transcripts is discussed in more detail in chapter 6 on data analysis.

other and their views anyway. Nevertheless, there is the potential of 'novelty', in that interview situations differ from conversations among the members of the élite. Here, interviewees might be more forthcoming if they know that the interview material will be non-attributable. Following this argument, then, the interviewees were assured that they as individuals would not be identifiable from the interview material. Subsequently, the interviewee was asked to briefly describe his/her formal position and responsibilities. The underlying idea was that this would provide valuable contextual information for the later analysis of the data.

The interview schedules were based on key dimensions of the occupational governance of nursing, which had been identified from the review of secondary literature and primary material. These concerned education, the division of labour in health care, management, personnel management, the health policy arena and nursing theories[10]. These were translated into general questions and more specific ones for probing. Interviewees were asked, for example, about their views on recent changes in the management of nursing services and how they had affected the influence of nursing; similarly, interviewees were asked for their opinions on the (proposed) reforms of nursing education and their implications for the division of labour in health care. While the broad areas of interest were the same for the interviews in Britain and Germany, the questions themselves reflected country-specific policy contexts. In the context of recent changes in community care, for example, the British interviewees were asked about the impact of the internal market, while their German counterparts were asked a similar question about the long-term care insurance. The interviews began with a general question on an issue, which was likely to be at the centre of the expertise of the interviewee. The officer of the Royal College of Nursing, for example, was asked about his views on the influence of nurses' interest groups on health policy. This was followed up by questions about the relationship with the trade union UNISON. This approach helped to produce a

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[10] For an overview of the development of these dimensions see figure 6.1 in chapter 6 on data analysis.

positive atmosphere, as these questions tend to be the least threatening. At the same time, it also provided a basis from which more specific or different questions could be asked, using the terms of the interviewee (Foddy, 1993: 61). While the majority of the interviews covered the intended set of issues, the order in which they were addressed was determined by the respondent. Immediately after the interview fieldnotes were taken, to document general observations about the interview situation and to note particularly interesting points which had been raised. The fieldnotes proved to be helpful in terms of learning from interviews, as well as in terms of 'contextualising' the recorded interview when producing the written summary. The fieldnotes on the very first interview, for example, noted that the answers of the interviewee had remained rather general. Against this background, the approach to probing was reviewed and the subsequent interviews produced more specific statements

Compared to the first part of the research the focus of the case study was more specific. The interview schedules were based on the operationalisation of the concept of internal boundaries, concentrating on decisions about the grade-mix and the division of labour in community nursing teams. While all the interviews concentrated on these two issues, the questions themselves took the specific position of individual interviewees into account. For example, while team leaders in the German case were asked directly about how work was allocated, the senior manager was only asked whether he had any influence over the process. Apart from that the interviews were conducted in much the same way as the élite interviews in the first part of the research[11].

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[11] In contrast to the first part of the research, though, the issues addressed in the interviews were more sensitive, as they concerned one specific locale. It is questionable, however, whether the interviewees would have been more open, if notes had been taken (instead of using a tape recorder). Nevertheless, the challenge of ensuring confidentiality was greater.

Focus groups

As part of the case study, focus groups were conducted with two community nursing teams in the locality in Scotland and North Rhine-Westfalia respectively. Here, the purpose of the focus groups, issues of sampling and the way in which the focus groups were conducted are discussed.

Focus groups are described as a research method which combines aspects of interviews and participant observation (Krueger, 1988: 45; Morgan, 1988: 20ff), in that they provide the opportunity both to observe interaction and explore the attitudes and experiences of informants. One of the central assumptions is that group interaction stipulates "self-disclosure": "The rationale is that the group environment allows greater anonymity and therefore helps individuals to disclose more freely ..." (Vaughn *et al.*, 1996: 19). It is stressed, that the group effect is maximised if the participants do not know each other. Thus, the literature advises against focus groups based on work settings (Krueger, 1988: 25, 28, 165; Morgan, 1988: 48)[12]. But in the context of the case study these concerns were less important, as the research was especially interested in the views of specific teams, as opposed to the views of community nurses in general. Here, the focus groups offered the additional benefit of combining observation and interviews. It was possible to do both: to explore the dynamics and interactions of the individual teams and to identify the specific views of the teams (and how they compared with those of other actors). With regard to the first aspect, the focus groups provided interesting insights into power relationships within the teams. In the British case, for example, the hierarchical relationship between the qualified and non-qualified members of staff could be observed, when one of the G-grades answered a question which was directly addressed to the nursing auxiliary. Similarly, the distance between the team leader and the community nursing

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12 However, this view has been modified in more recent articles on the topic. Krueger (1995: 530), for example, points to the success of research which uses focus groups in the work environment.

team in the German locality was reflected in the fact that the nursing staff consistently referred to the team leader using her formal job title, while they addressed each other by their first names.

Sampling fell into two parts, notably the initial selection of community nursing teams which would take part in the study and the selection of the participants. Although the first stage of sampling was carefully considered, it was of secondary importance due to the small size of the relevant population, that is the small number of community nursing teams within each local provider. The challenge, therefore, was not so much to choose the 'right' team, but to be aware of the particular features of individual teams. Notwithstanding the warnings in the literature (Vaughn *et al.*, 1996: 58) a certain degree of 'convenience sampling', therefore, was acceptable. Here, an important issue was the number of teams: in order to be able to compare and contrast it was crucial to include more than one team. Considering the in-depth nature of the study, it appeared to be most appropriate to include two community nursing teams in each locality. The initial choice and selection of the teams was largely left to the nurse manager/senior manager. This was not only a gesture of courtesy, respecting managerial hierarchies, but also facilitated access to the teams.

With respect to the selection of participants one option was to have separate focus groups with different types of staff, for example to restrict focus groups according to levels of training[13]. This would take power differentials within teams into account, acknowledging that less trained staff might feel intimidated by the presence of their superiors. But the research questions were not only general in their nature, but they also explicitly focused on the team and its decision-making as a collective entity[14].

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13 This is what Morgan (1988: 45) calls "theoretically chosen subgroups". Thus, a decision has to be made between mixing different types of participants and conducting separate groups.

14 Furthermore, this option would also have proved to be problematic in practical terms: as community nursing staff have highly individualised work patterns and locales, it was difficult to find a common time and place for the focus groups. Moreover, in the case of the Scottish locality the focus groups were scheduled for the summer, when many staff were on holiday

The focus groups, therefore, were based on the existing teams[15]. With regard to the issue of size Krueger (1988: 27) argues, that focus groups have to be " ... small enough for everyone to have opportunity to share insights and yet large enough to provide diversity of perceptions." The teams consisted of between 7 and 9 members in the Scottish locality and between 10 and 15 in the German locality. Considering natural absence as a result of sick leave, annual leave and work commitments between 6 and 8 participants appeared to be a realistic size. In order to ensure attendance, it was agreed that the focus groups should be part of a regular 'time together', that is the lunch break (in the case of the Scottish locality) and the team meeting (in the case of the locality in North Rhine-Westfalia). In addition, the teams were sent multiple copies of a letter explaining the research and the purpose of the focus groups. This approach worked well in three out of four teams.

As the focus groups were integrated into the routine of the teams, they took place on the premises of the community nursing teams. While this facilitated recruitment and attendance, the time which could be allocated to the focus groups was limited. The focus groups, therefore, only lasted between 40 and 50 minutes, in contrast to 90 minutes to 2 hours as suggested in the literature (cf. Asbury, 1995: 416; Krueger, 1988: 81). This considerably constrained the opportunity to observe group interaction and it was difficult to ensure the maximum involvement of all members of the group[16]. However, considering the practical limitations outlined above this appeared to be the best possible option. The focus groups began with a brief introductory statement which outlined the research, as well as the 'rules of the game'. This also provided an opportunity to introduce myself as the researcher and to help establish

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and when workloads, therefore, were particularly high. These problems would have been exacerbated if the participants of the focus groups had been recruited from different teams.

15 Similarly, Morgan (1995: 519) notes that, "... there is a potential conflict between recruitment issues that may lead towards using the widest range of possible participants, and sampling issues that may lead you toward using narrowly defined sets of participants to generate productive discussions".

16 In part, these disadvantages were counterbalanced by brief follow-up telephone conversations with two district nursing staff.

my credibility. Here, an attempt was made to strike a balance between referring to previous research experience in the field and emphasising the participants' role as experts. Moreover, the first set of élite interviews had also helped in gaining a certain level of familiarity with current issues surrounding the professional debate in nursing. Subsequently, the handling of the data was explained and the participants were asked for permission to audio-tape the focus group[17]. As this was the first encounter with the teams, the participants were asked to briefly introduce themselves. As with the interviews, the schedule for the focus groups concentrated on two topics, notably decisions about grade-mix and the division of labour.

In the context of conducting focus groups two issues are central. The first is the level of involvement of the "moderator", that is the person formally 'conducting' focus groups. Morgan (1988: 49; similarly Stewart and Shandasani, 1990: 11) argues that the more exploratory the research, the weaker the moderator's involvement should be, and the clearer the externally generated agenda, the greater the moderator's involvement should be. As the focus of the case study was specific, the second type of moderator involvement seemed to be more appropriate. Moreover, considering the existing time constraints, it was important to have the opportunity to cut off unproductive discussion. The second issue concerns the group dynamics themselves: in the group context individuals might be reluctant to voice disagreement; similarly, there may be problems involving every member of the group in the discussion. These problems had particular relevance for the case study, as there were clear power differentials (as expressed in different levels of training and experience) between different members of the community nursing teams. Thus, in order to counterbalance this individual participants were encouraged to contribute, either by eye contact or by directly addressing them. But the broadest possible participation of all team members was not necessarily essential, as one of the aims of the focus group was to observe

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[17] Issues of confidentiality are particularly important here, as "... the nature of the group discussion may elicit information more personal than the members anticipated" (Carey, 1995: 228, similarly Smith, 1995). For further explanation of the recording and the handling of the data see the relevant remarks earlier in this chapter.

(existing) team dynamics. Moreover, the case study focuses on the *management* of internal boundaries, in which team members are involved to *different* extents. In order to ensure that the points which the team viewed as relevant had been covered, participants were encouraged to raise any additional issues at the end of the focus group. Again, fieldnotes were taken shortly after the end of the focus groups. These were particularly useful for noting down the observations of the group interaction in the community nursing teams discussed above.

6 Analysis of data

There are different views regarding the nature of analysing data: an extreme view is taken by Schmid (1995: 320) who argues that in the case of semi-structured interviews the distinction between the collection and the analysis of the data often becomes blurred. In contrast others have a more narrow understanding of the process of data analysis and define it either as the handling of data, for example by coding it, or as the interpretation of data[1]. A third group of authors take an intermediate position: Morse and Field (1996), for example, stress that analysis consists of 'comprehending', 'synthesizing', 'theorizing' and 'recontextualising' data. Similarly, Miles and Huberman (1994) distinguish between data reduction, data display and conclusion drawing/verification. In the context of the research this last, broad understanding of data analysis is adopted[2].This chapter discusses the process of analysing the data gathered in the course of the research and begins by outlining the underpinning research approach. Then, it outlines how the data was initially organised. Finally, the challenges of interpreting the data are addressed by looking at the issues of validity, reliability, and generalisability.

Research approach

Research approaches can be understood as the interpretative framework or beliefs underpinning research, which are often referred to as research paradigms. In the literature the distinction between "qualitative" and "quantitative" is most common

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1 For an overview cf. Coffey and Atkinson (1996).

2 However, this does not mean to deny the existence of what Bogdan and Biklen (1982, as quoted in Bryman and Burgess, 1994: 7) call "analysis in the field" (as opposed to "analysis after data collection"), where the "... researcher needs to be constantly engaging in preliminary analytic strategies during data collection". As these decisions have already been discussed in more detail in the previous sections, this section adopts a more narrow understanding of data analysis..

(cf. Denzin and Lincoln, 1994; Janesick, 1994; Morse, 1994; Webb, 1993)[3]. However, it is argued (Guba and Lincoln, 1994: 105) that this terminology is misleading, as it suggests that research paradigms dictate research *methods*[4]. Alternatively, Guba and Lincoln (1994) distinguish between "received" and "alternative enquiry" paradigms, while Miles and Huberman (1994) use the terms "postpositivist" and "reflective". Among these Hughes' (1990) distinction between "positivism" and "interpretative alternatives" appears to be the most straightforward and it is adopted in this chapter[5].

Put simply: positivist research approaches assume that reality is objective, in that it is external to human beings. Thus, reality is observable (notion of 'empirical reality'). Positivist researchers, therefore, typically proceed deductively: they start with a hypothesis generated from theory, which is then tested by generating empirical evidence. Consequently, the research process focuses on explanation. The researcher him/herself is assumed (and required) to be distant from the object of his/her research. In contrast, interpretative research approaches assume that there are multiple realities: reality is subjective and is constructed by human beings. The research process, thus, focuses on exploring the ways in which individuals interpret their realities ('understanding', *verstehen*). Researchers following the interpretative paradigm typically proceed inductively: theoretical propositions are not determined at the outset, but emerge in the process of the collection and analysis of the data[6]. Research is seen as an interactive process (Denzin and Lincoln, 1994: 3): thus, the

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3 From a historical perspective this distinction is referred to as "positivism" vs. "hermeneutics" (Wright, 1994).

4 The underlying question is whether qualitative and quantitative research represent different epistemological positions or whether they are merely different research techniques (Bryman, 1988: 105ff).

5 For an overview of different research paradigms see Bryman (1988), Denzin and Lincoln (1994), Guba and Lincoln (1994), Hughes (1990), and Wright (1994).

6 However, this is not to say that interpretative research is without theory: "... in qualitative (interpretative) enquiry theory is used to focus the inquiry and give it boundaries for comparison in facilitating the development of the theoretical and conceptual outcomes" (Morse, 1994: 221).

researcher is a genuine part of study, and his/her personality, gender, ethnicity and past experience influence the research process. However, it is questioned, whether the epistemological position adopted determines the choice of research methods and whether positivist and interpretative epistemologies are indeed distinctly different (Bryman, 1988: 118f). In this context Miles and Huberman (1994: 4) argue that "At the working level, it seems hard to find researchers encamped in one fixed place along the stereotyped continuum between 'relativism' (interpretative approach) and 'postpositivism' (positivist approach)".

The research adopts this view and aims to integrate elements of both positivist and interpretative approaches. As such it corresponds to what Miles and Huberman (1994: 4) call "transcendental realist orientation": it is characterised by the dual belief that "... social phenomena exist not only in the mind but also in the objective world - and that some lawful and reasonably stable relationships are to be found among them." and that "subjectivity" exists and is important. Such a position seems to be particularly appropriate in the context of comparison. Here, the challenge is to deal with a considerable amount of data, which originates from different cultural contexts. The framework of analysis, therefore, has to be structured enough to establish a common basis for the comparison (that is, to compare like with like), but at the same time has to be broad enough to allow for exploration and difference. Consequently, the research starts off with a 'theoretically informed' framework which maps out the field of the governance of nursing in Britain and Germany. Using the concepts of occupations and institutions of health care, it points to central issues and dimensions of the analysis. At the same time, however, the analysis aims to explore individual dimensions of governance and their meaning and relevance in two different countries, as opposed to testing a hypothesis. Thus, the analytical framework evolved in the course of the different stages of the research[7]. More generally, this points to the interdependent relationship between theory and empirical

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[7] For a more detailed discussion see chapter 3.

research: "... theory suggests problems, but the answers given to those problems may then contribute to the development, refinement or confirmation of theory" (Roberts, 1978: 289). The aim of the research, then, was to integrate both understanding and explaining.

Organising the data

The stage of organising data corresponds to Morse's and Field's (1996) notion of "comprehending", which they characterise as "making sense of the data". Miles and Huberman (1994: 11) describe this as the process of "data reduction" "... that sharpens, sorts, focuses, discards and organises the data in such a way that 'final' conclusions can be drawn and verified". Organising the data, therefore, prepares the ground for the final part of the analysis, by making it more manageable and accessible. More specifically, it aims to establish a link between the data and the initial conceptualisation of the research topic (Bryman and Burgess, 1994: 5). In practice, organising data means to bring together different segments of the data, which have similar characteristics, by way of a thematic analysis (Coffey and Atkinson, 1996: 26f; Schmid, 1995: 321f). Insofar as these initial categories or themes are merely "heuristic devices for discovery" (Seidel and Kelle, 1995: 8, as quoted in Coffey and Atkinson, 1996: 30) they may change and some of them may even be discarded. Against this background, Morse and Field (1996: 108) suggest that categories should initially be kept as broad as possible and only when more data is accumulated should categories become more specific. In this context an interesting issue concerns the relationship between theory, data and categories: to what extent do the categories emerge from the data and to what extent do they reflect the initial theoretical conceptualisation of the research topic (Coffey and Atkinson, 1996: 31)? This is closely related to the original research question and the underlying research paradigm: if the research aims at testing a theory, the categories will be determined to a large extent by theory; if, however, the research aims at understanding a certain phenomenon, the categories will gradually evolve from the data itself.

Both parts of the research aimed to integrate inductive and deductive approaches and categories were informed by theory and the data itself. These played a central role in the process of comparison, in that the categories helped to reduce the volume and the complexity of the comparative data. Although the same set of categories was applied to the British and German data, the substance of the categories differed to some extent. This reflects the different ways in which the underlying issues are constructed in each country. In the context of Britain, for example, the management of nursing services assumes a prominent role, as it is part of the overall structure of health management in the NHS. It is of much less importance and more a micro issue in the German case, where the administration of health care is more dispersed. The development of the categories for the analysis in the first part of the research can be summarised as follows:

Figure 6.1 The occupational governance of nursing; development of categories

set of categories following...

(1) review of theories	**(2)** *first round* **review of secondary literature & primary material**	**(3)** *second round* **review of secondary literature & primary material**	**(4) analysis of élite interviews**
(1) education	(1) nursing education	(1) nursing education	(1) nursing education
=> [8]	(2) division of labour[9] in nursing =>		
(2) division of labour in health =>	(3) division of labour between nurses and doctors =>	(2) nursing and the division of labour in health	(2) division of labour in health care
=> [10]	(4) managing nursing	(3) managing nursing	(3) management of nursing services
=> [10]	(5) nurses' pay => [11]	(4) personnel management => [12]	
(3) organised interests and the arena of health politics	(6) nursing and the health policy arena	(5) nursing and the health policy arena	(4) health governance and organised interests in nursing
	(7) nursing theories and models	(6) nursing theories and models => [13]	

[8] The review of the secondary literature and the primary material suggested differentiating this category.

[9] The review of secondary literature and primary material characterised the division of labour in nursing, and between nurses and doctors, as part of the wider division of labour in health care. Against this background it seemed to be more appropriate to merge these two categories.

[10] This category emerged as a separate category from the review of secondary literature and primary material.

[11] The review of secondary literature and primary material emphasised that "nurses' pay" is part of the broader issue of "personnel management".

[12] The analysis of the interview data indicated, that the category "personnel management", encompassing skill-mix, pay and industrial relations, considerably overlapped with other categories, especially with "intra- and inter-occupational division of labour" and "nursing and the health policy arena" in the case of the last two aspects. Hence, the category was abandoned and integrated into categories 2 and 4 (fourth set) respectively.

[13] The analysis of the interviews suggested that "nursing theories and models" inform different dimensions of the governance of nursing, as opposed to being an issue on their own. Thus, this was abandoned as a separate category.

The first part of the research, which dealt with different dimensions of the governance of nursing in Britain and Germany, started off with a basic range of categories. This became more diverse as a result of the first review of relevant material and then contracted again following the second review and the analysis of the interview material. In summary, the initial set of categories was largely confirmed and only one category was added. The initial set of categories evolved from the critical review of the literature on theories of professions and the comparative literature on health care. These formed a theoretically-informed analytical framework, which was subsequently revised (and validated) by a two-phased review of secondary literature and primary material. The élite interviews represented a second round of validation: their purpose was to test the initial set of categories and at the same time to suggest changes, such as prioritising, merging or discarding the categories. Since the focus of this part of the research was general in its nature, the categories remained broad, although the analysis of the interviews helped to refine them to some extent. Categories were either redefined (for example from "nurses' pay" to "personnel management") or merged, such as in the case of "division of labour in nursing" with "division of labour between nurses and doctors". The principle underlying this process was that the categories would be adequate when ordering the material from the secondary literature and the primary material and the data from the élite interviews respectively. Another criterion was that the interview questions, which had been derived from the third set of categories, made sense to the respondents. In practice, then, the interview data was initially ordered according the third set of categories, which was revised following the analysis of the interviews. The final, fourth set of categories, then, provided the basis for the interpretation of the data itself[14].

In the context of the case study the process of generating categories was similar, although more straightforward. The initial set of categories evolved from the concept

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[14] For further specification of what these categories encompass see the analysis of the occupational governance of nursing itself (chapters 7-10).

of internal boundaries. It was operationalised by looking at decisions about grade-mix and the division of labour in community nursing teams. Following the analysis of the data from the interviews and the focus groups, a third category emerged, notably decisions about the practice of community nurses more generally. It helped to contextualise the initial two dimensions.

Interpreting the data

While the substance of the analysis is discussed in later chapters, the general issues underlying the interpretation of the data are addressed here. These can be captured in the concepts of validity, reliability, and generalisability. Although these apply to all phases of the research process, they are particularly relevant in the context of interpreting data. In addition, the different stages of interpreting the data are outlined.

It is argued that the origins of the concepts of validity and reliability lie in the positivist research paradigm and the concern about measurement errors (Brink, 1991: 166): validity, then, is defined as the extent to which certain indicators measure what they are supposed to measure; in contrast, reliability describes the intersubjectivity of the research process, meaning the extent to which repeated measurements lead to the same results. In order to ensure validity and reliability it is often suggested that one should use triangulation, defined as the "... conscious employment of multiple data sources and methods to cross-check and validate findings ..." (Begley, 1996: 122; similarly, Stake, 1994: 241)[15]. Moreover, Begley (1996: 122) emphasises that triangulation should be a continuous process, with the researcher adopting a "triangulation state of mind". Not surprisingly, there is some debate as to whether the concepts of validity and reliability are applicable to research which does not follow

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[15] Here, different types of triangulation can be distinguished (Begley, 1996: 123f): data triangulation, using multiple data sources all with a similar focus; investigator triangulation, with more than one researcher examining the data; theoretical triangulation, where all possible theoretical interpretations are tested in the context of the analysis; and methods triangulation, where more than one research method is used in a single study.

the positivist research approach. While some authors argue that validity and reliability should be modified and adapted, so that they fit interpretative research paradigms (cf. Brink, 1991), others advocate new ways of assessing rigour and validity of research. In this respect, Morse (1994), for example, suggests relying on the notions of "adequacy", meaning that sufficient data has been collected and that variation is accounted for and understood, and "appropriateness", meaning that information is selected according to the theoretical needs of the study and the emerging model. Similarly, Lather (1986, as quoted in Webb, 1993: 420) introduces the concept of "data credibility checks". Credibility, then, "... is evaluated by assessing whether participants' experiences have been faithfully represented ..." (Webb, 1993: 421). More generally, Morse (1994) advises keeping an "audit trail" and documenting the conceptual development of the project, so that interested parties can reconstruct the process by which conclusions have been reached.

While the research aimed to integrate positivist and interpretative research approaches this appeared to be difficult in the context of validity and reliability. The positivist interpretations do not fit the approach underlying the study very well. Although the initial research questions and analytical categories were clearly guided by theory, they did not amount to a clear hypothesis, which could have been translated into terms of measurement, let alone into terms of repeatable measurement. Thus, the notions of validity and reliability used in this study primarily follow the suggestions of the interpretative approach. In the context of the analysis of the data, a central concern was to check the credibility of emerging interpretations, both to ensure completeness of individual accounts as well as to distil common themes across different accounts. The general strategy of interpretation was to compare accounts within one category, between different respondents, and, more importantly, between Britain and Germany. This helped to develop a sense of both similarities and differences and of the underlying determining factors. Moreover, in the first part of the research the themes which evolved from the interview data were compared and contrasted with initial reviews of primary material and secondary literature. This helped to identify unexpected or interesting findings for a more detailed analysis. In

the German context, for example, the literature had stressed the potentially positive effects of the long-term care insurance in terms of enhancing the role of nurses, especially in relation to doctors. In contrast, the views of the interviewees were more cautious. This highlighted the need for further exploration. However, the accuracy of the interpretation was potentially challenged by the fact that the analysis in both parts of the research was based on summaries of the interviews and focus groups, as opposed to transcripts. As the research focused on the identification of general themes and patterns of decision-making respectively, the benefits of transcripts did not necessarily outweigh the considerable time needed to produce them. Summaries, therefore, appeared to be more appropriate[16]. The interpretation of the data, then, began with the writing of summaries. In order to ensure the accuracy of the interpretation, the summaries were not only compared with the fieldnotes, but a first draft was also sent to the interviewees, with the request for comments and amendments. However, in both parts of the research the interviewees and the participants in the focus groups made little use of the opportunity to comment on the summaries. Finally, notes were kept of the different phases of the research and the evolving interpretations of the data. These 'records' were used to check the credibility of the interpretations, by tracing back the way in which they evolved and thereby comparing and contrasting them with the preceding interpretations. The interpretation of the case study material, for example, relied to a considerable extent on a comparison with the results of the macro-analysis. Among other things, it challenged the initial notions of a cohesive/fragmented approach to governance.

Traditionally, the notion of "generalisability" has been defined as a special type of validity, notably external validity: it describes the extent to which research findings can be generalised to factors like different settings and populations. From a positivist

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16 Due to their nature as summaries, it appeared appropriate to use indirect speech when referring to them in the context of the analysis. The summaries of the German interviews and focus groups, thus, have not been translated into English. In the context of the case study, however, individual quotes were retrieved from the tapes, in order to illustrate the findings of the analysis.

perspective it is argued that the external validity of interpretative research tends to be weak. Interestingly, this has been echoed by interpretative researchers themselves, who have tended to assign low priority to generalisability (Schofield, 1994: 200f). However, this is changing and "... a consensus appears to be emerging that for qualitative researchers generalizability is best thought of as a matter of the 'fit' between the situation studied and others to which one might be interested in applying the concepts and conclusions of that study" (Schofield, 1994: 221). This presupposes a detailed description of both the substance and the process of research. A similar debate exists with regard to case studies, which are traditionally thought to provide little ground for generalisation[17]. While some authors try to redefine the notion of external validity, others present a more radical approach. Following the first position Yin (1989: 21), for example, points out that "... case studies, like experiments, are generalizable to theoretical propositions and not to populations or universes". This means it is necessary to distinguish between analytical and statistical generalisation. In contrast, the second group argues that case studies provide a stronger basis for valid generalisations than positivist research, as causality is based on plausibility and not representativeness (Stoecker, 1991: 92ff; similarly Bryman, 1988: 101).

As discussed earlier in the context of the selection of localities, the study is based on the assumption that there are no exceptionally typical cases, in that every case is special. This clearly limits the scope for generalisations. Nevertheless general remarks, rather than generalisations, may be possible due to similarities between Britain and Germany as two industrialised Western countries. The issues at the macro level of health policy and the micro level of occupational practice, for example, are likely to be similar to some extent. Thus, the research aimed at going beyond explaining the individual case. In the context of the research, this is reflected in the fact, for example, that a micro case study was chosen to further elaborate the

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[17] For an overview of this critique see Stoecker (1991: 91) and Yin (1989: 21).

occupational governance of nursing (analysed from a macro-analysis) and to relate it to the wider institutional structure of the health system.

THE OCCUPATIONAL GOVERNANCE OF NURSING

As argued earlier, studying nursing is interesting as it plays a major role in the provision of health care in Europe, while it seems to be at the margins of the health policy agenda. Here, the comparative approach provides the opportunity to explore what difference different institutions of health care make against the background of the similar challenges confronting nursing in Britain and Germany. However, the review of the literature (chapter 1, 2) suggested that there is no ready-made framework for the comparative analysis of nursing. Instead, it was argued combining the (micro-) analyses of occupations with a (macro-) analysis of health systems (chapter 3). The research focuses on two sets of questions: how is nursing as an occupation governed? How is this influenced by the institutional context of health systems? The following chapters (7-11) analyse different dimensions of the occupational governance of nursing from the macro-perspective. Particular attention is paid to the modes of governance, the underpinning institutional structures, the actors involved and the more general dynamics in which governance takes place. The aim is to locate the occupational governance of nursing in the institutional context of health care in Britain and Germany. The analysis covers developments until autumn 1997, when the fieldwork for this study was completed. This is particularly relevant in the case of Britain, where the new Labour government published a White Paper in December 1997, outlining the dismantling of the internal market (Department of Health, 1997). Meanwhile, the proposed changes are being implemented and GP-fundholding, for example, has been replaced by primary care groups with effect from 1 April 1999.

As discussed in chapter 6 on data analysis, the initial set of dimensions of the occupational governance of nursing were derived from the salient issue of defining nursing. In the course of the reviews of the literature on nursing and the analysis of the élite interviews these dimensions were further developed and expanded and/or contracted. The analysis in the following chapters is based on the final set of

dimensions. They are ordered according to the principle "from general to specific", and include:

1. health governance and organised interests in nursing,
2. nursing education,
3. the management of nursing services, and
4. the division of labour in health care.

The analysis begins by examining the governance of health care in Britain and Germany and the role of nursing within it (chapter 7). It is argued that in both countries nursing tends to be at the margins of health governance. In the case of Germany this is further exacerbated by the fragmented structure of nurses' interest groups. The next chapter focuses on nursing education, its organisation and the actors involved (chapter 8). It is suggested that the modes of governance differ. In Germany, a fragmented legal framework co-exists with (localised) self-regulation by employers, while in the case of Britain the statutory self-regulation by professional bodies is central. Subsequently, the management of nursing services is analysed (chapter 9). In Britain, it is embedded in a highly vertically integrated system of health administration, whereas in Germany fragmented legalism is combined with self-regulation by provider organisations. Nevertheless, in both countries there is considerable scope for micro-politics. This renders the role of nursing and the influence of nurse managers uncertain, particularly due to the gendered nature of care and the dominance of the concern for cost-efficiency. Finally, the governance of the division of labour in health care is examined, focusing on the relationships between qualified and non-qualified nursing staff and between nurses and doctors (chapter 10). It suggests that considering the limited scope of formalisation by credentialism and legalism, in both countries micro-politics is the dominant mode of governance. However, it is contingent upon gender and the type of work setting, as well as upon situational and individual factors. The conclusions compare and contrast the different aspects of the analysis (chapter 11). Particular attention is paid to the different modes of governance, to different levels of governance and to the differences and

similarities between Britain and Germany. Further, some methodological implications of the analysis are discussed.

7 Health governance and organised interests in nursing

Health governance describes the institutions, actors and mechanisms governing health care, as reflected in the organisation of the financing, provision and regulation of health care[1]. These are also pointers to the power relations underpinning health governance, that is the actors involved, and the influence they have. The aim of this chapter is to analyse the institutions and actors of health governance in Britain and in Germany and to locate nursing within the system of health governance. The influence of nursing, however, is not only predicated on institutions, but is also influenced by the way in which their interests are organised, whether they are fragmented or cohesive.

It is argued that the governance of health care in Britain and Germany reflects the differences between a national health service and a social insurance system, which particularly manifest themselves in the role of the state. In Britain as well as in Germany nursing tends to be at the margins of governance, reflecting not only the institutional dominance of doctors, but also the dominance of the concerns of purchasers and providers within (managerial) discourses about cost efficiency and containment. In Germany, this is exacerbated by the fragmentation of organised interests in nursing. Although their British counterparts are more cohesive, the stance of the Royal College of Nursing, as a professional organisation, is also increasingly challenged.

The institutional context of health governance

The institutional context of health governance reflects the characteristics of two different systems of health care, that is a national health service and a social

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[1] For a more detailed discussion of the concept of governance see the relevant section in chapter 2 on the comparative study of health care.

insurance system. While both countries operate on the basis of a "public contract model", in Britain this is embedded in a system of centralised financial control and agenda setting. In contrast, the influence of the federal government in Germany is more indirect, following the historically and institutionally entrenched notion of self-administration of health care.

The health care system in Britain is a national health service, and it operates on the basis of the "public contract model" (OECD, 1992), that is a separation between public third-party payers and providers of health care which relate to each other through contracts[2]. The National Health Service (NHS) is largely financed out of general taxation and its expenditure is fixed by the Treasury as part of the government's annual budget. This gives central government considerable control over the financing of health care. The main challenge, then, is not so much to contain costs, but to meet potentially increasing demand within a fixed budget. Thus, there is greater emphasis on the *administration* of health services. This also points to the implicit aim of a *national* health system to provide services equitably across the country. Central government has a prominent role in the administration of health care, reflecting the public nature of the NHS. But it also relies on sub-central tiers of administration, the health authorities, which purchase health services for the population in their area[3].

Doctors play a central role in the provision of health care services. Ambulatory medical care is provided by general practitioners (GPs), who are independent contractors. They have an important gatekeeping function, as patients depend on GPs' referrals to be admitted to hospital and to see a specialist. These are exclusively

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2 For overviews of the British health care system cf. Allsop (1995), Baggot (1998), Ham (1997c). While the recent reforms of the NHS under the Labour government have "abolished" the internal market, the split between purchaser and provider organisations has been retained (Department of Health, 1997). However, annual contracts have been replaced by more long-terms "service agreements".

3 The Scottish equivalent are 15 local health boards.

based in hospitals and thus there is a clear separation between ambulatory and hospital care. In recent years, there has been an increasing emphasis on care outside hospitals, which has coincided with a more influential role for GPs, especially as fundholders[4]. In contrast, hospital and community health care is provided by self-governing trusts. The financing of these trusts is based on contracts with the purchasers of health services, that is health authorities and those GPs who hold their own budgets (fundholders)[5]. In principle, contracts specify the cost, quantity and quality of services. This is particularly feasible in the case of fundholders, as they purchase *specific* services for *their* patients. The scope of health authorities' contracts, in contrast, is more extensive, as they have to cover all health needs of the entire population in a given area. Thus, they often take the form of block-contracts, defining "... a set number of patient episodes over a period of a year for a global sum" (Allsop, 1995: 177).

Nurses have traditionally worked in hospitals and, to a lesser extent, in community care settings. More recently, they have also increasingly been employed by GPs as practice nurses. These are "... characterized by a flexible and generic role, encompassing a wide range of work in the practice and in the patients' home" (Atkin and Lund, 1996: 86)[6]. The pay of nurses is based on a clinical grading scale, which is

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4 As part of the implementation of the Labour government's White Paper "The new NHS" (Department of Health, 1997), with effect from 1 April 1999, fundholding has been replaced with primary care groups. These build on and develop existing forms of locality commissioning. They comprise not only the GP practices in a given area, but also community nurses and social services. They are responsible for the planning, provision/commissioning and development of health services in their area. Primary care groups are envisaged to develop gradually; eventually, they are expected to become primary care trusts, that is free standing bodies, accountable to the health authority. For further details also see House of Commons (1999), NHS Executive (1999a). In Scotland, the corresponding White Paper was entitled "Designed to Care".

5 However, "... the NHS internal market reforms were a little slower to take off in Scotland, so the number of trusts and the percentage of the population covered by fundholders has tended to lag behind the rest of Great Britain" (Baggot, 1998: 122). This was echoed by a number of interviewees, who pointed to the continued importance of socialist and collectivist orientations in Scotland.

6 The role of nurses working in the community and their ties with GPs has been highlighted by the recent reforms of the NHS and the new primary care groups comprise GPs as well as

'priced' on an annual basis and funded by the government[7]. It tends to follow the recommendations of the independent Review Body for Nursing Staff, Midwives, Health Visitors and Professions Allied to Medicine, whose members are appointed by the government. The recommendations are based on evidence collected by the Review Body and provided by professional organisations and trade unions. However, the continued existence of the Review Body has become uncertain, as its recommendations are not binding for self-governing trusts; at the same time, government is pushing for local pay determination. In reacting to these challenges the Review Body suggests introducing a two-tier system, which would link local and national pay determination (cf. Review Body for Nursing Staff, Midwives, Health Visitors and Professions allied to Medicine, 1996). Commenting on future developments an officer of the Royal College of Nursing, in its twin role as professional organisation and trade union, suggested that local pay determination was certain to become more widespread. Similarly, Grimshaw (1999: 296) argues that "in some cases, (trusts) see the design of local pay scales for HCAs (health care assistants) as a pilot experiment for the transferral of all nurses from national to local pay scales". In contrast, the officer from the trade union UNISON was more cautious. He argued that compared to other sectors of the labour market full-scale local pay determination in the NHS was neither in place nor likely to be in the near future[8]. Here, he pointed to the reluctance of trusts to get involved in what is a potentially controversial issue. Moreover, existing financial constraints also allow trusts little flexibility (Buchan, 1992).

In summary, the NHS combines the characteristics of a centralised health service, that is a high degree of vertical integration, with the features of a "quasi market" managed by actors at local level through contracts. Thus, while there is scope at local

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nurses (Department of Health, 1997). Here, it will be interesting to see how influential nurses are compared to GPs.

7 For an overview of the discussion of pay determination cf. Buchan (1992), Grimshaw (1999).

8 The 1995/6 report of the Review Body (1996: 2) suggested that 5% of staff currently work under distinct trust terms. Similarly, Bryson et al. (1995: 132).

level in terms of the provision of services and negotiation of contracts, both are firmly embedded in a system of centralised financial control and monitoring of performance. The prominent role of purchasers and providers, combined with the dominance of a managerial agenda also means that nurses do not necessarily take part in the governance of health care at local level[9]. Instead, they are more likely to depend on central government to take initiatives on their behalf.

The German health system, in contrast, is based on a compulsory insurance model. It consists of the statutory health insurance (*Gesetzliche Krankenversicherung*), which covers ambulatory, hospital and medically-related aspects of community health care, and the statutory long-term care insurance (*Pflegeversicherung*), which covers non medically-related community health care. Both insurance schemes are financed equally by employer and employee contributions, which are paid on monthly earnings. In the case of the health insurance, contributions are set by individual insurance funds and they are adjusted to meet changing expenditure levels. The contributions to the long-term care insurance, by contrast, are fixed and were set by the initial federal legislation introducing the new insurance. Health care, then, is administered by self-governing, non-profit, statutory insurance funds. These also negotiate contracts and pay with the providers. The control over financial resources and health care expenditure, therefore, is fragmented. However, health insurance funds have to follow an income-related expenditure policy (*einnahmeorientierte Ausgabenpolitik*). This means, that the rise of expenditure must not exceed the rise of wages, so that insurance contributions remain stable. The same is true for the long-term care insurance, although the mechanisms to contain costs are more rigid: not only are the contribution rates fixed, but the federal government can also adjust the remuneration of providers.

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[9] For a more detailed discussion see chapter 9 on the management of nursing services.

As health care is largely defined as medical care, doctors play a dominant role in the provision of health care. Office-based doctors are self-employed and comprise generalists (*Allgemeinärzte*) and specialists (*Fachärzte*). Patients have to register with an office-based doctor for a minimum period of three months. But as referrals are merely a formality, patients in effect have direct and unlimited access to any kind of office-based doctor. At the same time, however, there is a clear separation between ambulatory care and hospital services, as office-based doctors have a gatekeeping function. In contrast, the provision of hospital care is heterogeneous and it is divided more or less equally between public, non-profit and private hospitals (Alber, 1992: 78). While investments are financed by state governments, insurance funds pay for the operating costs of hospitals. Funding is based on a combination of fixed rates per day and occupied bed and, more recently, fixed payments on the basis of diagnosis-related groups. The provision of community care is also fragmented. Traditionally, it has been dominated by local non-profit providers who belonged to one of five main umbrella organisations. The long-term care insurance, however, has opened the provision of community care to private, for-profit providers. Providers are reimbursed on a fee-for service basis.

Nurses predominantly work in hospitals and to a lesser extent in community care, reflecting the prominence of hospitals in the provision of health care. In ambulatory settings, office-based doctors largely work single-handedly, but employ so-called "medical assistants" (*Arzthelfer/innen*) who do not have a nursing qualification as such. The pay of nurses follows the federal pay-scale for public sector employees (*Bundesangestelltentarif*). However, as an officer of one of the trade unions pointed out, the pay scale contains few provisions for staff working in community care settings. She argued that this was problematic, not only because community care was expanding, but also because new private providers, in particular, were reluctant to accept the minimum standard of the pay scale for public sector employees. Pay rises and changes to conditions of work are negotiated between provider organisations and trade unions at national level.

These structural features result in a large number of actors and they also reflected at the level of regulation. Here, negotiations and collective bargaining prevail within a general framework of corporatism. It is institutionalised in different forms of sectoral self-administration (*Selbstverwaltung*) (Alber, 1992: 157f), from which nurses, however, are excluded. Firstly, insurance funds and associations of insurance fund doctors, as independent statutory associations, exercise "self regulation". Health insurance funds, for example, have traditionally set their own contribution rates. Secondly, there are "inter-organisational negotiations" between associations of insurance funds and providers. As these deal with contracts which set terms and conditions as well as expenditure levels, they are likely to be more confrontational in their nature (Alber, 1992: 158). In contrast, and thirdly, the style of "collective bargaining" between insurance funds and provider organisations at federal level is more consensus-oriented, as both sides are more removed from their membership.

The institutional context of the governance of health care in Germany, then, appears decentralised, if not fragmented, as power is scattered between multiple actors and arenas of decision-making across different levels. Moran (1994: 94), thus, characterises German health policy as a "search for control". However, there are various factors which promote institutional co-ordination and integration. Wilsford (1994: 259), for example, points to the importance of "... coordinating umbrella organizations that work to centralize a good bit of the policy process". At the same time, all decision-making ultimately takes place within the framework set by federal law. This is strengthened by the legalistic nature of governance in Germany (Dyson, 1992). Integration is also promoted by the basic principles underlying the German model of health care, such as solidarity and self-administration. These serve as a common cognitive frame of reference for the different actors involved in health governance (Döhler and Manow-Borgwardt, 1992b: 67).

The actors in health governance

In both countries, the actors central to health governance are the state; the purchasers of health care, that is health authorities/fundholding GPs and insurance funds respectively; and the providers of health care, that is doctors, hospitals and community care providers. In contrast, and significantly, nurses are not a clearly identifiable actor in health governance[10]. Apart from the role of the state, the difference in the nature of purchasers and providers is particularly interesting. The social insurance system in Germany was built on existing insurance and provider structures. Ultimately, therefore, they are non-state organisations integrated into a statutory health system. Thus, in comparison to Britain, where purchasers and providers are still very much part of a public health service, interest organisations in Germany play a more important role. This is strengthened by the fact that they are part of an inter-linking system of negotiations at state and federal level.

In Britain, the Department of Health is at the centre of the state's governance of health care. Whereas the Secretary of State is responsible for the development of policy, the NHS Management Executive oversees the operation of the NHS and the purchasing of health care more specifically. While the separation between policy and operational matters aimed at making the structure of the Department of Health more cohesive, it has proved difficult to distinguish clearly between the two (cf. Allsop, 1995: 190). The Department of Health with the NHS Management Executive as its 'operational arm' is at the top of a highly vertically integrated structure of health care administration. The centre not only allocates money to health authorities, but also sets the framework in which they operate. This is done through guidance and circulars, the setting of priorities, requirements and objectives and the development of performance indicators (Baggot, 1998: 154f). There is an ongoing debate about the nature of centre-periphery relations in the NHS. There appears to be some agreement

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[10] For a more detailed discussion of their role in purchaser and provider organisations see chapter 9 on the management of nursing services.

that the developments in the 1990s have been ambiguous, in that they are characterised by moves both towards decentralisation and increasing centralisation. Allsop (1995: 188), for example, suggests that while responsibility "... now lies with a large number of smaller agencies ... central government nevertheless continues to dictate the agenda". Similarly, Baggot (1998: 153) points to a strategy of "decentralising blame", whereby the centre seeks to strengthen its control of the NHS, while devolving the responsibility for services to local actors. In contrast, Klein (1995: 215) argues that decentralisation has merely been rhetorical, while the NHS has become more centralised than ever before: "Almost 50 years after the NHS was first created, in the second half of the 1990s it had become a *national* service" (emphasis in the original).

While both health authorities and fundholding GPs are responsible for the purchasing of health care, their specific outlook differs. Health authorities purchase the full range of health care services for the entire population in their area. But Ham (1997c: 50) stresses that health authorities are more than insurers: "Purchasers do not simply reimburse providers for delivering care to patients but are actively involved in determining needs and the most appropriate way of responding to those needs". In contrast, the purchasing of fundholders is restricted to their patients and to certain health care services, although this has gradually expanded. Thus, there are two separate and potentially competing purchasing organisations, whose priorities differ: health authorities tend to be interested in stable, long-term relationships with providers, while fundholders can be much more flexible (Allsop, 1995: 177)[11]. Although purchasers can be regarded as separate actors in health governance, the organisation of their interests tends to be weak. Not only are their roles relatively

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[11] However, the contractual system is likely to be more stable, where GP fundholders operate as multi-funds, pooling their budgets for joint purchasing, or where health authorities have created locality commissioning groups with GPs to discuss service priorities (Baggot, 1998: 207). Greater stability is also one of the main themes of the recent health care reforms of the Labour government, replacing the internal market with "integrated care" (Department of Health, 1997). Thus, annual contracts are substituted by long-term service agreements which are embedded in local health improvement programmes.

new, but health authorities, in particular, are *de facto* part of the centre's health care administration. The same is true of the trusts providing hospital and community care.

Due to the existence of local monopolies, the internal market has not necessarily resulted in increased competition between providers. However, the existence of separate purchasers, together with more diverse contractual arrangements has challenged the power of providers and acute hospitals in particular (Ham, 1997c: 53ff). They now have to market their services more actively and are held accountable for their performance. Moreover, with the introduction of fundholding, the position of GPs vis-à-vis hospitals has been considerably strengthened. This is echoed by the debate about moving towards a "primary care-led" NHS (NHS Executive, 1996)[12]. While GPs, as the providers of ambulatory medical services, have been a central part of the NHS, they have remained independent contractors. Compared to other providers, therefore, private interest organisations play a more important role. Here, the British Medical Association is almost in a monopoly position. Historically, it has represented the medical profession at large and, thus, became the preferred point of contact for the government. Within the British Medical Association the General Medical Services Committee acts on behalf of GPs on issues of both professional politics and industrial relations.

In Germany, the state primarily comprises the federal government and, more specifically, the federal ministry of health (*Bundesministerium für Gesundheit*). Its role is largely regulatory in its nature and it provides the statutory framework in which insurance funds and providers operate[13]. The limited role of government is a corollary of the fact that health care is financed by statutory, but independent,

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12 This has been confirmed by the introduction of primary care groups, as part of the Labour government's reforms of the NHS. For more details see footnote 4 in this chapter.

13 In contrast, state governments approve federal legislation in the second chamber (*Bundesrat*), and are responsible for hospital planning and investment, as well as for the regulation of medical education. Due to their vested interests as providers, they have long exercised considerable veto power in the context of hospital reform.

insurance funds and that the governance of health care is dominated by different forms of self-administration[14]. However, the legitimacy of a more interventionist role of the federal government increases if the institutions of self-administration are seen to fail. The ongoing concern for cost containment since the late 1970s has provided such a condition. More specifically, Döhler and Manow-Borgwardt (1992b) suggest that the 1980s have seen a gradual expansion of self-administration, but that this has been accompanied by stronger hierarchical elements. These include: tighter deadlines for reform implementation; stricter measures to ensure cost containment such as capped budgets for hospital expenditure; or fixed contributions for the long-term care insurance.

The structure of the statutory health (and long-term) care insurance has traditionally been highly heterogeneous, consisting of over 1000 individual insurance funds (Schulenburg, 1994: 1473). These largely operate through peak associations at state and federal level. Also, the number has considerably fallen following the 1993 health reform, which gave patients a free choice of insurance funds with effect from January 1998. The insurance funds fall into two groups, basic insurance funds (*Primärkassen*) and substitute funds (*Ersatzkassen*). This distinction largely reflects historical legacies, and since the 1980s the statutory health insurance has become more centralised and standardised. Its political influence has also benefited from the fact that it has become the "natural ally" of the state in its attempt to contain health care expenditure (Alber, 1992: 168).

Providers of health care fall into three groups, notably office-based doctors (ambulatory care), hospitals and community care providers. The interests of office-based doctors are represented by a wide range of professional organisations. The

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[14] Webber (1992b: 210) summarises the role of federal government by arguing that it is engaged in "procedural", rather than "substantive" regulation: while the former is concerned with " ... the stipulation of the 'rules of the game', which lay down how decisions are to be reached in the sector ...", substantive regulations describes "... the making and implementation of the concrete decisions concerning the funding and the delivery of health care".

majority of these are academic in their nature and are concerned with specialist areas in medicine, while only two explicitly focus on 'professional politics'[15]. Moreover, in order for office-based doctors to provide services under the statutory health insurance they have to become members of one of the regional associations of insurance doctors (*Kassenärztliche Vereinigung*). These assume an intermediate position between professions and the state: on the one hand they represent doctors' interests, for example in negotiations with insurance funds over pay, and on the other they have statutory responsibilities, such as organising the remuneration of their membership (Webber, 1992a: 214ff). By comparison, the organisation of the interests of hospitals is fragmented and there are no statutory bodies (Alber, 1992: 78ff). However, there is some concertation between the 11 different umbrella organisations at state and federal level, in that the *Landes-* and *Bundeskrankenhausgesellschaft* provide a forum for joint discussions. The organisation of community care providers, in contrast, is more coherent and has operated on quasi-corporatist terms (Meyer, 1996: 185). Most local providers still belong to one of the five non-profit welfare organisations (*freigemeinnützige Wohlfahrtsverbände*), which reflect historical divisions along ideological lines. However, at local, state and federal level they tend to co-operate closely through joint committees. At the same time, following the principle of subsidiarity, these non-profit organisations have traditionally been given a privileged position in the provision of publicly-financed welfare services.

Organised interests in nursing

The level of influence of nursing is not only predicated upon the institutions of health care, but also depends on the way in which they are organised. In both countries nurses' interests are represented by professional organisations and trade unions. In Germany, this distinction is cross-cut by a historically-rooted cleavage between

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[15] For an overview see cf. Schulenburg (1984).

religiously- and secularly-oriented nursing, which makes the representation of nurses' interests more fragmented[16].

In Britain, whereas a wide range of different professional organisations represent individual specialities in nursing, the Royal College of Nursing (RCN) is concerned more widely with professional politics. Its membership, however, is restricted to qualified nurses and nursing students. Here, an officer of the Royal College pointed out that there was increasing willingness among the membership to admit support workers. However, he expressed concern that this might endanger the status of the Royal College as a professional organisation. As such its primary focus is on developing nursing practice and standards of care through education and research (Royal College of Nursing, 1995).

The situation in Germany is similar. There are two main professional organisations, reflecting historical divisions between formerly dominant religiously-oriented nursing and gradually emerging secularly-oriented nursing (cf. Möller and Hesselbarth, 1994: 189ff; Schulte and Drerup, 1992). Whereas the *Deutscher Berufsverband für Krankenpflege* (DBfK) has a secular orientation, the *Arbeitsgemeinschaft Deutscher Schwesternverbände* (ADS) acts as an umbrella organisation for religious nursing groups. Traditionally, these two organisations have tended to compete against each other. But despite continuing differences at the level of principle, there has been increasing co-operation in recent years[17]. Both organisations, for example, are members of the *Deutscher Bildungsrat*, which is an umbrella organisation promoting the reform of nursing education (Pflege Aktuell, 1995). Similarly, as an officer of the religiously-oriented ADS explained, a joint

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16 Moreover, the percentage of nurses who are members in either type of organisation also appears to be much lower in Germany than in Britain. Haug (1995: 94), for example, estimates that only 23% of hospital nurses are members of a professional organisation, compared to 65% in Britain. Similarly, trade union membership is 22%, compared to 54% in Britain.

17 At the same time, as the officer of the religiously-oriented professional organisation stressed, the outlook of both organisations has also become more similar, as her organisation has embraced more mainstream 'professional views'.

committee at federal level provides a forum to work together on specific issues of professional politics. One of the driving forces behind co-operation is the shortage of financial resources (Haug, 1995: 84), due to comparatively small memberships. Considering this rather fragile position, as well as external challenges such as resource pressures, the closer co-operation between these two professional organisations can also be interpreted as a 'survival strategy'. Nevertheless, in comparison to Britain the representation of nurses' interests remains more fragmented. Also, the organised interests in the German case appear to be relatively volatile. In summer 1997, for example, four of the DBfK's state-level organisations declared their independence and set up separate professional organisations (Mayer, 1997).

In addition to professional organisations, nurses are also represented by trade unions[18]. In Britain, the public service trade union UNISON covers nursing. It is an amalgamation of formerly separate trade unions, among them the Confederation of Health Service Employees (COHSE) and the National Union of Public Employees (NUPE), which have been nursing's traditional representatives[19]. Since the 1970s trade union membership in nursing has increased. In part, this appears to have been a result of the introduction of an industrial model of management in the late 1960s, which also led to a considerable increase in the number of non-qualified nursing staff (Harrison and Pollitt, 1994: 63ff). In reacting to this challenge, the RCN tried to expand its membership base and to strengthen its trade union activities (Hart, 1994: 123; Thornley, 1996). It introduced a steward system and since the late 1970s it has been recognised as a trade union, although it is not affiliated to the Trade Union Congress. Nevertheless, the RCN stresses its unique character as a 'professional trade

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[18] In Britain, in particular, there is some overlap between these two forms of interest representation, as the Royal College is both a professional organisation and a trade union.

[19] Whereas the former largely focused on psychiatric and mental health nursing, NUPE primarily addressed the interests of junior nursing grades and non-qualified nursing staff. Besides traditional clienteles, the pattern of membership in these trade unions was also influenced by the specific political orientations of individual work settings (Bagguley, 1992: 295ff).

union', combining the functions of a trade union and a professional organisation (Clay, 1987). But interestingly, for the UNISON officer interviewed, the professional orientation of the Royal College remained paramount. This was echoed by his RCN counterpart, who emphasised, that it was only in relation to particular issues that the Royal College adopted a trade union stance. The RCN, then, does not appear to have truly reconciled its two organisational identities. Moreover, the officer of UNISON suggested that considering the changes in the NHS and the accompanying job insecurity, the professional orientation of the Royal College has become increasingly untenable. This suggests that because of the more radical position taken by the trade union, it may find itself in a better position to respond to the increasing politicisation of nursing issues. In addition, the trade union side has potentially become more powerful with the creation of UNISON as one single trade union. In terms of membership, UNISON even has slightly more (nursing) members than the RCN, as its membership also includes nursing auxiliaries and health care assistants[20]. In terms of the relationship between the two, the officer of the Royal College made an interesting differentiation, arguing that while it was adversarial at the national level of professional politics, dialogue and co-operation prevail with regard to local issues of trade union representation.

In Germany, the membership of nurses in trade unions has traditionally been weak. In part, this reflects the historically important role played by religious nursing orders and middle-class women's organisations; they fostered an occupational ideology, which conceived nursing as a vocation rather than as paid work (Bischoff, 1994a). The trade unions open to nurses are the *Gewerkschaft Öffentliche Dienste, Transport und Verkehr* (ötv) and the *Deutsche Angestellten Gewerkschaft* (DAG)[21]. In contrast to their British counterparts, trade unions in Germany are directly involved in

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20 In 1998, for example, the RCN had 317 000 members compared to 455 000 members in UNISON's health branch (UNISON, without year, b). However, the latter figure does not exclusively include nursing staff. The figure for the RCN is based on a telephone conversion with the Membership Department. Time series were not available for public use.

21 For an overview cf. Möller and Hesselbarth (1994: 93ff), Muselmann (1994).

negotiations regarding pay and working conditions. Interestingly and contrary to the traditional scepticism of nursing towards trade unionism, 1991 saw the creation of a new trade union, the *Gewerkschaft Pflege*. Its membership is restricted to nurses, intending to ensure a more satisfactory representation of nurses' interests (Mönig, 1992). The officer of one of the established trade unions was sceptical of its influence, especially because of its small membership. In contrast, the *Gewerkschaft Pflege* argues that this may change, with a growing number of providers going private and with fewer nurses, therefore, working under the federal pay scale for public sector employees (Boll, 1994). Commenting on the relationship between trade unions and professional organisations more generally, the trade union officer observed that the two are increasingly in agreement that co-operation was needed on certain policy issues. This view was echoed by the officer of a professional organisation, although she stressed that the different orientations of each organisation limit the scope of co-operation.

Discussion

Health governance in Britain and Germany takes place in two different systems of health care: that is a national health service and a social insurance system respectively. But with the introduction of the purchaser-provider split in Britain the two systems have become more similar, both operating on the basis of the "public contract model". Nevertheless, important differences remain, particularly in terms of the role of central government which is greater and more direct in Britain.

Both countries have in common, however, that nursing is at the margins of health governance, although it plays a central role in the provision of health care[22]. In Britain and Germany, health care is largely defined as medical care and doctors assume a prominent role in the provision of health care. This particularly manifests

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22 Against this background, Bräutigam (1995: 76f) and Robinson (1991: 302), for example, describe nursing as an "area of non-decision-making".

itself in the role of GPs and office-based doctors as gatekeepers. Their position is further strengthened by their new role as purchasers in the case of Britain. Similarly, in Germany office-based doctors are at the centre of the regulation of health care through the system of joint self-administration. Thus, medical dominance is sustained in institutional terms. Moreover, nurses, as professionals are not a constituent part of the purchaser-provider relationship. However, despite the physical exclusion, the other participating actors may still take on nursing interests. However in both countries this possibility seems to be limited as purchasers and providers operate within an agenda of managerialism and cost efficiency, in the case of Britain, and of cost containment, in the case of Germany[23].

In principle, the same is true for the respective governments. However, Bertilsson (1990) suggests that the importance assigned to "caring occupations" depends on the extent to which the principle of social citizenship is institutionalised. The more this is the case, the more are social services situated in the public as opposed to the private sphere. Thus, those sectors in which nurses work gain greater 'public' importance. It could be argued that this is more likely to be the case in Britain, whose national health service is based on (social) citizenship rather than employment, which is the case under the German social insurance system. Beyond the likelihood of the interest of the state, its potential for intervention also varies. While the federal government in Germany is increasingly influencing the parameters of purchaser-provider negotiations, its ability to intervene more directly remains limited. The central government in Britain, in contrast, can operate through multiple layers of sub-central administration and its power even seems to have increased in recent years, although there is the parallel trend of decentralisation. In summary, although in both countries

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[23] This distinction goes back to Freeman's (1998a) argument that national health services and social insurance systems have different agendas for reform. In the British NHS the emphasis on cost efficiency reflects the central challenge to meet increasing demand, without significantly increasing resources. Due to the centralist nature of funding, containing costs is not a problem as such. The reverse applies to Germany, where control of funding tends to be fragmented.

nurses are at the margins of health governance, in Britain this is counter-balanced by the ability (and potential interest) of the state to intervene.

There are similar differences in the organisation of nursing interests, which have potential repercussions on the influence of nursing. In Britain, not only is the percentage of nurses who are members of the main professional organisation and trade union higher, but the representation itself is also more cohesive. The Royal College of Nursing is in a dominant position and trade unions are amalgamated to form a single organisation. But the position and influence of the Royal College and its status as a professional organisation is challenged, as issues such as staffing levels and grade-mix, which are traditionally the main concern of trade unions, have become more important. In contrast, in Germany the representation of nurses' interests is more fragmented, reflecting historical divisions between religiously and secularly-oriented nursing. Although there have been more instances of co-operation between the two main professional organisations in recent years, they still remain divided. Their scope is further limited due to their small membership bases.

8 Nursing education

Education plays an important role in defining what nursing is and what it does. It "... captures the quintessence of the struggle of an occupational group to create and recreate its identity and place in the social division of labour" (Chua and Clegg, 1989: 106). Neo-Weberian theories of professions go even further to argue that credentials are a powerful means of social closure, in that they demarcate occupational territory. Thus, credentials are an important element in establishing a legal monopoly over the provision of services through licensing by the state (Parkin, 1979: 57). At the same time, and not surprisingly, education is a salient issue in nursing, where its reform is widely regarded as a means of attaining 'professional status' for nursing[1]. Here, recurring concerns about shortages of qualified nurses frequently act as a catalyst for putting nursing education on the political agenda. In both countries, recent debates about the reform of nursing education are heavily influenced by the new nursing paradigm and its focus on a stronger academic orientation[2].

This chapter analyses the governance of nursing education. Here, a distinction is made between "first-level education" which refers to initial training, leading to a (general) nursing qualification; and "second-level education" which describes subsequent and more specialised training, leading to an additional qualification. This terminology corresponds to the distinction between "pre-" and "post-registration education" commonly used in the British debate. But in order to acknowledge that there is no professional register in Germany, the more generic terminology is used. It

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1 For Britain cf. Jolley, 1987; for Germany cf. Bolles, 1995. Historically, however, education has been in a weak position within nursing itself: since nursing was considered as a vocation 'character-building' was paramount. It was only with the increasing specialisation of medicine, that a different kind of training was required (for Britain cf. Burnard and Chapman, 1990; for Germany cf. Bischoff and Wanner, 1993).

2 For an overview of the debate on the reform of nursing education in Britain cf. Dolan (1993), Kendrick and Simpson (1992), Tattam and Thompson (1993); for Germany cf. Bischoff (1994c), Dielmann (1993a, b), Forschungsgesellschaft für Gerontologie (1996).

is argued that the organisation of first-level education in particular differs between the countries: there is a strong academic emphasis in Britain, whereas the training schemes in Germany are more practice-oriented. These differences at the level of organisation also seem to manifest themselves in the distribution of power between actors: while in Britain nursing has considerable influence through statutory professional bodies, in Germany the interests of employers tend to prevail. In the conclusions it is argued that these differences also point to the degree of cohesiveness and scope of the respective regulatory frameworks. In the context of the analysis of the occupational governance of nursing, regulation is treated as a specific mode of governance, understood as a framework of rules and formal procedures. These can take the form of self-regulation by nurses/employers or legalism.

The organisation and structure of nursing education

There are interesting variations in the organisation of nursing education. Particularly since the reforms in the mid 1980s, first-level nursing education in Britain has become more academically-oriented, which manifests itself in the move of nursing colleges into higher education and in the supernumerary status of nursing students, that is the fact that they are not formally treated as part of the work force. In comparison, first-level nursing education in Germany remains more practically-oriented, as is reflected in nursing colleges being run by hospitals and in the dominance of apprenticeship-based training in clinical settings. But this situation is potentially challenged by recent moves to establish nursing studies as an academic discipline. Similarly, the structure of qualification differs: Germany is characterised by a clear focus on hospitals; British nursing qualifications, in contrast, are more generic at primary level and there are established community care-oriented qualifications at secondary level.

In Britain, first-level education is provided by institutions of, or related, to higher education, that is colleges and universities, in association with health care providers[3]. It is regulated by a statutory professional body, the United Kingdom Council for Nursing, Midwifery and Health Visiting (UKCC) and its four National Boards, and is purchased by the Scottish Office[4]. In contrast, in England, first-level education is purchased by trusts or trust consortia. The curriculum consists of 50 percent academic study and 50 percent work experience, although the share of academic study is greater in the first half of the training (two thirds compared to one third). The academic orientation of first-level education is also reflected in the fact that for 80% of their training nursing students have supernumerary status. Moreover, by the end of their training they receive both a diploma in higher education and a professional qualification.

After a common foundation programme nursing students choose a specialism for the second half of their 3 year training, that is either care of adults, care of children, care of people with learning difficulties or mental health care. The common foundation programme and the combination of placements in hospital and community care is based on the notion of the 'knowledgeable doer', who is able to work in a variety of health care settings (UKCC, 1987). Thus, two interviewees, a nursing and quality adviser from a health board and a nursing officer of the Scottish Office, concluded that overall first-level nursing education had become more generic, despite the specialisation in the second half of the training. However, they stressed that the scope of practice of these newly-qualified nurses was not comparable with that of specialist community nurses. Moreover, with the gradual phasing out of the enrolled nurses grade, training schemes have been introduced for support workers. These are part of

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3 For an overview of nursing education in Britain cf. Murphy (1993), Rogers (1993).

4 The regulatory structure of nursing education will change following the government's review of the Nurses, Midwives and Health Visitors Act, which started in 1997. For more details see below, footnote 13.

vocational training schemes and lead to the qualification of health care assistant[5]. This move is significant, as it identifies more clearly the educational framework of support workers by providing a national recognition of their qualifications (Richardson and Wheatsley, 1995). At the same time, this upgrading provides a potential link between non-professional and professional qualifications and thereby potentially downgrades the latter. Specialist second-level education is also regulated by the UKCC and the National Boards. Institutions of higher education have traditionally provided the qualifications with a community care orientation, such as district nursing. By contrast, specialist training in clinical nursing areas, such as intensive care or accident and emergency, has tended to be offered by NHS schools in collaboration with specialist hospitals.

The current structure of first-level education reflects the changes which followed a report by the UKCC in 1987, the so-called "Project 2000". Its thrust reflects recent approaches within nursing, which aim to develop concepts of care that are distinct from the prevailing medical model of cure and that stress the importance of academic knowledge and training[6]. The reform itself, however, was a response to a wider range of pressures, among which the concern about shortages of qualified nurses was particularly prominent (UKCC, 1986; Naish, 1993). In the past, this problem has primarily been addressed by increasing the number of nursing students. But with declining birth rates the pool of potential recruits is limited. This has contributed to a debate about making nursing more attractive by reforming first-level education. In

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5 In Scotland, these are co-ordinated by the Scottish Vocational Educational Council; the English counterpart is the National Council for Vocational Qualifications (NVQs).

6 For a critical overview cf. Porter (1994), Salvage (1992), Witz (1994). These are often subsumed under the terms "new nursing" and "primary nursing". The widespread popularity of these approaches within nursing can be explained by the fact, that they are, first and foremost, considered as a strategy to advance nurses professional status. In contrast, Salvage (1988; similarly Ramprogus, 1995) emphasises that the corresponding reorganisation of education should not be viewed as a covert quest for traditional professional status, but as a "struggle for survival" through the evolution of a new occupational model. The underlying assumption is, that the focus of current health policy initiatives on cost and efficiency challenges nursing considerably.

this respect the reforms following on from "Project 2000" challenged the apprenticeship model, in that they stressed the importance of academically-oriented learning, complemented by work-experience.

In Germany, first-level nursing education is provided by local hospital-based colleges[7]. It is subject to federal legislation and is financed by employers, out of the reimbursement for provision of hospital care. First-level education consists of one third classroom teaching and two thirds practical training in different, but mainly hospital-based, settings. The practical emphasis of first-level education is reinforced by the fact that nursing students are regarded as part of the work force[8]. Moreover, it still largely follows the apprenticeship model and the principle of "learning by doing" (cf. Bischoff and Botschafter, 1990: 800). Not surprisingly, therefore, clinical mentors are not formally qualified teachers, but tend to be experienced staff nurses who might have had some in-house training. Until recently, classroom-based teaching was dominated by medical subjects. Although this has not been reversed by the 1985 reform of the respective federal law, the importance of care-related topics has increased. Nevertheless, medical subjects still account for half of the curriculum (Forschungsgesellschaft für Gerontologie, 1996: 61).

There are three modes of first-level education: general nursing (*Krankenschwester/pfleger*), paediatric nursing (*Kinderkrankenschwester/pfleger*) and enrolled nursing (*Krankenpflegehelfer/in*). The bias towards hospital-oriented qualifications (and training) not only reflects the dominance of hospital care in the overall provision of health care, but also the historical development of community

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7 Although nursing colleges are backed by a specific hospital, they are formally independent and are accountable to state governments (Wander, 1992: 6).

For an overview of the organisation and structure of nursing education cf. Forschungsgesellschaft für Gerontologie (1996), Kaufmann (1992a, b).

8 The calculation of staffing levels in hospitals, for example, is based on the assumption that the working capacity of a nursing student equals a seventh of that of a full-time equivalent employee (Bräutigam, 1995: 44).

nursing[9]. In contrast, second-level education is more varied, reflecting the heterogeneity of providers combined with a patchy regulatory framework. But as part of the move to establish nursing studies as an academic discipline, degrees in nursing management and pedagogy at polytechnics (*Fachhochschulen*) and universities have become a growth industry in recent years (cf. Schaeffer and Moers, 1993: 32)[10]. These developments have received further impetus from German unification, as nursing studies was an academic discipline in the former GDR (Beikrich, 1992)[11]. In addition, it could be argued that current health care reforms, with their emphasis on cost containment, put nursing under pressure to define more clearly its contribution to the provision of health care. This challenges the weak theoretical underpinning of nursing care and the corresponding practice-orientation of nursing education (cf. Winter-von Lersner, 1995). In contrast, first-level education plays a less prominent role in the debate about reform. Here, a professor of nursing studies pointed out that this primarily reflects present reform blockades. While some of the state governments are committed to change, the federal government currently does not see any need for reform. Moreover, organised interests in nursing are split over the question of reform. While there is general agreement over the integration of different care-related training schemes, only the trade unions call for nursing education to become part of the general regulatory framework for vocational training[12].

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9 For a more detailed discussion see chapter 12 which introduces the case study.

10 For an overview of the different degree courses cf. Deutscher Berufsverband für Pflegeberufe (1996), Lohr and Landenberger (1994a, b).

11 As the moves to establish nursing studies as an academic discipline are relatively recent, the German debate has closely followed the Anglo-American "new nursing paradigm". However, this is increasingly criticised, in that these theories cannot account for the specific institutional context in which German nursing practices (Löser, 1998; Schröck, 1998). Moreover, Bischoff (1994a, b) points out that nursing has turned to these concepts precisely at a time when cost containment became the predominant issue in health policy. Here, the new nursing paradigm with its strong emphasis on the well-being of patients provides a powerful ideology to conceal the negative impacts of funding cuts.

12 The first aspect of the reform would put greater emphasis on more generally applicable knowledge and the acquisition of specialist knowledge would be restricted to the later stages of the training, or even to specialist second-level training. This rests on the assumption, that the boundaries between different health and social care occupations have become increasingly blurred, especially in community care. For an overview of the debate cf. Forschungsgesellschaft für Gerontologie (1996: 224ff), Dielmann (1998).

The actors in nursing education

A wide range of actors potentially have a stake in the governance of nursing education: nurses, their employers, who are also the providers of health care, the payers of nursing education and health care services, as well as the providers of education. It is argued that there are interesting variations in the distribution of power between them, reflecting different types of governance of nursing education. In Britain, statutory self-regulation gives a prominent role to nursing itself, even in the face of more localised educational arrangements, including greater influence by the purchasers of health care. In Germany, in contrast, the interests of employers tend to dominate, reflecting the fragmentation and limited scope of the legalistic regulatory framework.

In Britain, nursing education is regulated by the United Kingdom Council for Nursing, Midwifery and Health Visiting (UKCC) at UK level and four National Boards (NB) in England, Wales, Scotland and Northern Ireland. The UKCC is a statutory body, and was formed in 1980, replacing the General Nursing Council (GNC). As a statutory body which is independently funded by registration fees, it is accountable ultimately to Parliament, through the Department of Health. Also, 20 out of 60 members of the UKCC's Council are appointed by the Secretary of State and he/she also has to clear any legislative changes proposed by the UKCC. While the UKCC maintains the register of qualified nurses and sets standards of professional conduct and education, the National Boards are responsible for monitoring, that is approving educational institutions and validating first and second-level training courses. In contrast to the UKCC the National Boards are executive non-departmental public bodies, which are government-funded and whose chairperson and board members are appointed by the respective Secretary of State[13].

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[13] The present regulatory structure will change following the government's review of the Nurses, Midwives and Health Visitors Act. In response to a report by independent consultants (J M Consulting, 1998) the government announced in February 1999 that the UKCC and the National Boards will be replaced by a single, UK-wide statutory body, the Council for Nursing

Although both types of bodies are distinct from professional interest representation, they are in effect based on professional self-regulation, which gives nurses considerable influence on the governance of education. Analysing the policy process leading to the reform of nursing education, James and Jones (1992: 12), for example, suggest that the UKCC "... could give greater political powers of negotiating by providing a body which would speak authoritatively ... and which embodied within its remit the requirement of professional self-regulation". This was echoed by a nursing officer of the Scottish Office. She argued that the role of the National Board meant that considerable power over education had been devolved to nursing itself. But in addition to the potential influence of government, the scope of the UKCC and the National Boards is potentially also limited by the financial constraints in health care, as reflected in the implementation of Project 2000, and the influence of the purchasers of nursing education. For first-level education this is the Scottish Office; but as a nursing officer of the Scottish Office explained, the contracts only specify the number of qualifications at each level and leave the accreditation of education providers and courses to the National Boards. In the case of second-level specialist education, trusts act as the purchasers. But the nursing officer of the Scottish Office emphasised that it is particularly in their roles as employers and health care providers that trusts play an important role in first-level education, in that half of the curriculum is delivered in clinical settings. Also, the training of the health care assistants is outside the remit of the UKCC and the National Boards.

However, there were different views as to the impact of the purchaser-provider split on the governance of education. An officer of the National Board argued that the

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and Midwifery (NHS Executive, 1999b). At the same time, there will be specific arrangements in Northern Ireland, Scotland and Wales for overseeing the implementation of the standards set by the Council. Furthermore, there will be a review of the regulation of the work of support staff. Interestingly, the initial report as well as the response by the government also indicate a change in emphasis. They stress that professional regulation is based on the need to protect the public, rather than on the right of a profession to regulate itself. Provisions for changing the regulatory structure have been included in the Health Bill in April 1999. Currently, specific proposals for new legislation are being drawn up in consultation with relevant bodies and organisations.

purchasers of health services had become more influential and that there was increasing scope for local variation[14]. She pointed out that this also had implications for the role of the National Board, in that it now had to provide a flexible framework and to ensure that training was adequate in relation to locally specified needs. In contrast, a chief nursing adviser/director of planning and development of a health board and a director of nursing/community general manager of a trust both stressed that at present purchasers had little influence on the training of the staff providing health care. But both acknowledged that purchasers might become more powerful in the future, with the further development of the purchaser-provider split and with contracts becoming more sophisticated. However, despite the greater scope at local level, and the potentially greater influence of purchasers of health care, the role of the UKCC and the National Board still seems to remain significant. A director of nursing/community general manager of a trust emphasised that the UKCC guidance functions as an authoritative blueprint for decisions at trust and practice level. More generally, she also pointed out that as an independent and statutory body the UKCC enjoyed high status and widespread recognition. The situation with respect to second-level education is similar, in that it is also regulated by the UKCC and the National Boards. Here employers have a potentially greater influence, as they are the purchasers.

In Germany, first-level nursing education is regulated by federal law, that is the *Gesetz über Berufe in der Krankenpflege* and the *Ausbildungs- und Prüfungsordnung für die Berufe in der Krankenpflege*, which is implemented at state level. As part of this legalistic approach the state, in principle, assumes a central role in the governance of education, while nursing is much less directly involved. But this is not necessarily the case, as the regulatory framework itself is fragmented and limited in its scope. In terms of the curriculum, for example, the federal law only provides a

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[14] Similarly, a nursing officer of the Scottish Office pointed to the considerable scope local providers of education have, in conjunction with representatives of providers of health care, in respect to curriculum development.

general framework with further specifications to be made by state legislation. So far, this is only the case in three states (with North Rhine-Westfalia not being one of them)[15]. Thus, this allows not only for considerable scope at local level, but there is also no strong regulatory body at either federal or state level, which could act as a countervailing power. Consequently, employers assume a central role in nursing education: they are strongly involved in the provision of education, as they effectively run nursing colleges and as nursing students spend the majority of their training in the workplace. Moreover, while most other vocational training schemes are regulated by the *Berufsbildungsgesetz* nursing is subject to separate laws. In historical terms, this exceptionalism has been fostered by an occupational ideology which stresses vocation and the pivotal importance of practice as opposed to theoretical knowledge (cf. Bischoff, 1994a). As a result, nursing education has been isolated from the education system at large and from the changes it has undergone (cf. Bals, 1993; Beier, 1993: 162f). As a professor of nursing studies explained, nursing education is in effect a hybrid between secondary school education and vocational training.

The situation is similar in the case of second-level education: although regulation formally lies in the hands of the state governments, it is patchy[16]. Relevant legislation exists in 11 states (including North Rhine-Westfalia), although the majority of it is relatively recent. It often consists of framework legislation, that is *Weiterbildungsgesetze*, which provides the basis for guidelines for specific training schemes. But the range of schemes covered varies considerably. Instead, employers are in an influential position, in terms of both the provision and the regulation of education. Thus, the provision of training courses has traditionally been in the hands of institutions affiliated to the major employers in health care, especially the churches

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15 Thus, curricula are likely to differ considerably between local nursing colleges. In practice, they are discussed with the relevant department of the administration at state level and interestingly its medical director is responsible for monitoring them.

16 For an overview see Forschungsgesellschaft für Gerontologie (1996: 71ff).

and other ecclesiastic bodies. It is only since the 1970s that providers related to trade unions and professional interest groups, and more recently commercial providers, have become more influential. The heterogeneity of providers manifests itself in a great variety of second-level education, both in terms of contents and format (Lohr and Landenberger, 1994). But in part this has been compensated for by a form of self-regulation, in that the guidelines of the umbrella organisation of hospitals (*Deutsche Krankenhaus Gesellschaft*) have gone some way towards standardising second-level training (Forschungsgesellschaft für Gerontologie, 1996: 71f; Stöcker, 1994a). Here, an interesting development has been the creation of the *Deutscher Bildungsrat* in 1993. It was founded by the main professional organisations in nursing and within its focus on educational issues one of its aims is to develop guidelines for second-level education. It can be seen as an attempt by nursing to get hold of a territory which has long and strongly been dominated by employer interests. This last aspect was also reflected in the comments by a director of nursing and the officer of a trade union. They perceived nursing education to be primarily externally determined, that is by the financial considerations of employers or wider health policy initiatives, rather than by nursing itself.

Discussion

The analysis of the organisation and structure of nursing education suggests that the British and German case can be best understood in terms of a contrast between academic and practice-orientation. It manifests itself in the affiliation of nursing colleges and in the ratio between class-room teaching and clinical practice, as well as in the extent to which nursing students are treated as part of the work force. These organisational differences also seem to be reflected in the distribution of power between actors: whereas in Britain nursing itself plays a prominent role through bodies of statutory self-regulation, the fragmented and limited legalistic framework in Germany allows for the interests of employers to be highly influential.

Thus, the differences at organisational level not only reflect the different outlooks of the dominant actors, but also the characteristics of the respective regulatory frameworks. The governance of nursing education in Germany is based on legalism, whose regulatory capacity is not, in principle, weaker than that of statutory self-regulation. The crucial difference, then, is that in comparison the approach in Britain tends to be more cohesive and gives the respective regulatory body more scope. The regulatory framework in Germany is more fragmented: it is dispersed over 16 state governments, many of whom have not made use of their legislative powers. At the same time, the legislative powers of the federal government are limited. Taken together, these features further strengthen the already considerable influence of employers in the governance of nursing education. Thus, while there is scope at local level in both countries, in Germany there is no countervailing power in the form of a strong regulatory body.

9 The management of nursing services

From a comparative perspective it is difficult to define the term "management", since its meaning appears to be culturally-specific: there is, for example, no direct German translation, which captures the broad meaning of the original term and instead the English word is often used. Moreover, in the context of current British health policy "management" is closely associated with the concept of New Public Management and the managerial reforms of the Conservative government since the mid 1980s (cf. Cox, 1991; Harrison and Pollitt, 1994). In contrast, in Germany the debate about New Public Management has been much less influential and it has largely been confined to local government (cf. Klages *et al.*, 1995). But the different importance attached to management also reflects institutional differences: due to the public nature of the NHS there is greater emphasis on administering health care services, for example, to ensure equity of funding and provision of services across the country. At the same time, following the centralist structure of the NHS the state also has greater power to influence health care services, indeed it is the top tier of health service administration. There is no comparable need and capacity for (central) administration in the German system, in which the financing, provision and regulation of health care has traditionally been more decentralised, being dispersed between different levels and different actors[1].

In the context of this chapter "management" is understood in general terms, as all those activities which are not directly concerned with the delivery of care. The relevant literature suggests drawing a distinction between "clinical" management, which focuses on the planning and monitoring of care, and "organisational management", that is the management of nursing *services* as such. The different perceptions of management were also reflected in the interviews. The German

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[1] For a more detailed discussion of the health system in Britain and Germany see chapter 7 on health governance.

interviewees largely focused on issues of "clinical", as opposed to "organisational management". Here, particular emphasis was put on the development of quality standards, which had also been encouraged by recent health policy initiatives.

Considering the focus of the research on the occupational governance of nursing, this chapter is concerned with the "organisational management" of nursing services. More specifically, it analyses the wider institutional and policy context in which management at micro level takes place. The underlying assumption is that beyond these contextual factors, management is strongly influenced by the arrangements and politics of individual locales. The chapter begins by analysing the overall approach to organising the management of nursing services. It is argued that the notion of 'managing nursing' as a distinct part of the governance of health care services is much stronger in Britain than in Germany, although there have been interesting changes in recent years. Further, the involvement of different actors in the management of nursing services is discussed. It is emphasised that compared to the influence of administrators/general managers and doctors the position of nurses at the level of providers tends to be weak. This is even more the case at the level of purchasers, although for different reasons. The chapter concludes by arguing that despite differences in the administration of health services more generally, in both countries the management of nursing services is governed by micro-politics. However, this is predicated upon structural factors and the gendered nature of care, in particular.

The organisation of management

The analysis of the organisation of managing nursing services in Britain and Germany suggests that the degree of formalisation varies, reflecting more general characteristics of health governance. In Britain, the management of nursing services is part of a highly vertically integrated structure of health care administration. However, there has been some change of emphasis as well as increased scope at local level, following reforms since the mid 1980s. In Germany, the management of

nursing services is subject to a fragmented regulatory framework of federal/state legislation and guidelines from umbrella organisations of non-profit providers.

In the case of the NHS in Britain, the development of the management of nursing services has been strongly influenced by the importance assigned to administering health care services more generally. In addition, the high degree of vertical integration in the *National* Health Services appears to have facilitated the involvement of different groups in management, particularly those, like nurses, which tend to be weak in structural terms[2]. The Salmon Report in 1966 is considered as a milestone for nursing management in hospitals, as it introduced a coherent, multi-tiered and professionally-based management structure (Carpenter, 1977: 173ff)[3]. Nursing management, therefore, meant "management of nursing services by nurses". The direction taken by the Salmon Report was consolidated by the 1974 NHS reorganisation. In theory, its concept of consensus teams placed nurses as equals beside doctors (Carpenter, 1977: 182ff). While this may not always have been the case in practice, it fostered the notion that nurses have a place in the management of health care services, within both hospitals and health authorities. Thus, it gave nurses, as professionals, guaranteed access to the different administrative tiers of the NHS. But the sheer quantity of involvement does not necessarily say anything about its quality. A director of nursing/community general manager, for example, argued that the focus and purpose of senior nursing management posts was often not clear. This was echoed by a nursing officer of the Scottish Office, who felt that these posts had not been vested with real responsibilities and, therefore, had lacked decision-making power. Both comments suggest that the focus on professionally-based hierarchies did not necessarily affect the nature of decision-making processes and the

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2 For an overview of the historical development of the management of nursing services cf. Ralph (1989). For a more general overview of health services management cf. Harrison and Pollitt (1994).

3 The changes of nursing management in community care followed a similar pattern (McIntosh, 1985: 49ff): on the basis of the Mayston Report in 1969 a three tier management structure was introduced, which was consolidated by the 1974 NHS reorganisation. For a more general overview of the management of community nursing services see Ottewill and Wall (1990).

corresponding power relations. Similarly, medical dominance was not questioned: new career opportunities for nurses were restricted to management, whereas the clinical development of nursing was neglected.

The introduction of general management in hospitals and health authorities following the Griffiths Report (1983) marked a clear departure and the newly appointed general managers had considerable freedom in setting up alternative management structures (Harrison and Pollitt, 1994: 48). Here, Cox (1991: 106) stresses that the Griffiths reforms imposed a 'non-negotiated order' on hospitals and, thereby, fostered an adversarial 'industrial them-and-us culture'. These changes were consolidated by the creation of the internal market and independent trusts in the early 1990s. As a result, the structure of the management of nursing services became more diverse and the emphasis on efficiency and operational issues further challenged the influence of nurses as professionals, within both provider and purchaser organisations. Interestingly, a chief nursing adviser/director of planning and development of a health board observed that at the same time the concept of general management has been increasingly challenged within the NHS. He suggested that instead, nurses are seen to have a legitimate role in management, combining professional and managerial credibility. Similarly, a nursing officer of the Scottish Office argued that recent years had seen moves away from a rigid general management approach towards greater concern with clinical effectiveness, going some way towards reconciling managerial and professional views[4]. Here, Harrison and Pollitt (1994: 143ff) also argue that the further expansion of rigid managerialism is limited. They refer to the influential position of "professionals-turned-managers", to the possibility of "decentralising blame" by leaving operational decisions to professionals and, more generally, to the negative public image of "managers".

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[4] For an overview of the different measures of quality assurance cf. Baggot (1998: 149ff). Similarly, quality assurance is a central theme of the Labour government's recent reform of the NHS, as reflected in the establishment of a "National Institute for Clinical Excellence" and a "Commission for Health Improvement" (Department of Health, 1997).

In Germany, the involvement of nurses is confined to the management of health care providers, while the insurance funds as the purchasers of services are dominated by employers and employees who are the financiers of health care. The management of provider organisations tends to be professionally-based, consisting of a tripartite executive board of chief administrator, medical and nursing director. But the precise managerial structure varies between providers, reflecting the fragmented regulatory framework (Haubrock, 1994: 221; Wander, 1992: 2). In principle, the management of hospitals is subject to state legislation (*Landeskrankenhausgesetze*). However, as its scope is limited to public hospitals, it in effect only applies to one third of hospitals. In contrast, the management of the remaining two-thirds of non-profit and private hospitals follows the guidelines of the respective umbrella organisations (which often resemble the state legislation). More specifically, the management structure of hospitals depends on the type of 'business' the hospital is registered as (*Rechtsform*), which is either prescribed by law or chosen by the respective umbrella organisation. To some extent this also determines the actual functions and responsibilities of directors of nursing, and these are further specified by contracts of employment (Wander, 1992). The same is true for community care providers: while management structures are part of federal legislation (*Sozialgesetzbuch V* and *XI*), its actual provisions remain rather general. Although the management structure of provider organisations is likely to vary between different locales, this does not necessarily mean that nurses are not involved. However, it indicates that the notions of management and managing nursing services more particularly, are much less institutionalised than in Britain.

The actors in the management of nursing services

In both countries, nurses are involved in the management of health care services, primarily at the level of providers and to a lesser extent at the level of purchasers. Here, Britain has seen a shift from "professional" to "general" management, challenging the nature of the management of nursing services and the involvement of nurses within it. Although there are similar pressures, nurse managers in Germany

have retained their position as "professionals in management". But regardless of these differences, in both countries the influence of nurses in management tends to be weak compared to general managers/administrators and doctors. In part, this reflects specific organisational features, but it also points to structural factors, such as the low status of nursing care in the provision of health care. As the management of nursing services in Germany is confined to provider organisations, and also not embedded in a wider system of health service administration, the relevant literature tends to be more concerned with micro-analyses. This is also reflected in the discussion that follows.

In the British context, it is ironic that while the introduction of general management was mainly targeted at the medical profession, its effect on nursing was perhaps by far the greatest (Harrison *et al.*, 1992: 81): it largely dismantled the existing professionally-based management hierarchy and challenged both the management of nursing as an activity, as well as the involvement of nurses within it. Moreover, with the introduction of the internal market and the creation of independent trusts, management structures have also become more diverse, varying significantly between different locales. Porter (1995: 146f; similarly Alaszewski, 1995: 64f) argues that the impact on hospitals has varied according to different tiers of management: following the flattening of management structures the ranks of middle management shrank considerably, while the role of the ward sister expanded to incorporate in many cases budgetary responsibilities. Thus, the managerial career ladder has become shorter and the importance of management at ward level has increased, as a nursing officer of the Scottish Office and a director of nursing and quality of a trust stressed. The situation of senior management posts is more complex. As the two nursing advisers of health boards emphasised, compared to purchasing authorities where nursing posts have become purely advisory, directors of nursing in trusts have more extended management roles, as they are still members of

the executive board[5]. Due to financial pressures, the continued existence of these posts is being challenged, as a director of nursing and quality of a trust observed. Moreover, the nature of these posts has changed[6]. Some posts have retained their specific focus on nursing, but their function has shifted to being advisory and "... new roles in advisory, support, and quality assurance have been created under the control of the general manager ..." (Ulusoy and Smith, 1996: 104). Alternatively, although nurses may still hold senior management positions, these often have a strong operational focus, which does not necessarily provide a basis for addressing questions about the nature of service needs. A director of nursing and quality of a trust, for example, felt that due to high demands on efficiency there was little room for developing practice. Thus, (nursing) care may become a blind spot (Davies, 1995: 191), with the status and legitimacy of managing nursing services being challenged. Moreover, management has become much more distinct from clinical nursing practice. This change manifests itself in the move from professionally-based to general management. The question of distinct skills needed for management has become more important. However, nurses may not have the relevant management skills (Howley *et al.*, 1995: 315; Ulusoy and Smith, 1996: 104f). But a director of nursing/community general manager of a trust argued that from early on in their careers nurses learn how to manage teams and more and more nurses are gaining formal qualifications in management.

In summary, the management of nursing services has been challenged by the shift from professionally-based to general management, which focuses on addressing operational issues. A director of nursing/community general manager of a trust suggested that this may have strengthened the credibility of nurses' input, as it is now based on skills rather than just professional background. More generally, as

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5 However, trusts are under no statutory requirement to include nursing director in their executive board.

6 For a general discussion of the impact of general management on nursing see Cox (1991: 102ff).

management reforms have tended to focus on curbing the power of doctors, they have been much less concerned with nurses as such. At the same time, due to the comparatively low status of care nurses in management and the managers of nursing services are likely to be in a weaker position compared with doctors and general managers. In their study of the Resource Management Initiative, Keen and Malby (1992: 869), for example, observe that doctors and managers did not necessarily recognise the legitimacy of nurses' claims to a role in management. The more influential role of doctors in management was also acknowledged by the two nursing advisors of health boards and a director of nursing and quality of a trust. Besides the more powerful position of doctors in health care, they also pointed to the fact that in career terms doctors are less dependent on managerial positions, as they can go back to clinical practice[7]. This also raises more general questions about the importance of structural power differentials, such as between care and cure, for understanding the management of nursing services.

In Germany, following the legislation at state level and the guidelines of the umbrella organisations of providers, most hospitals have a tripartite executive board, which consists of three formally equal posts: the director of nursing services (*Pflegedienstleiter/in*), the medical director (*Ärztliche/r Leiter/in*) and the chief administrator (*Verwaltungsleiter/in*). Directors of nursing have the overall responsibility for nursing services; this includes planning, implementing and controlling standards of nursing care, ensuring the efficiency and quality of nursing care, staff development and organising the practical training of nursing students[8]. However, compared to the medical director and the chief administrator the director of nursing services is often less influential (cf. Küpper, 1994: 31f)[9]: in comparison to medical practice, nursing care is perceived as low status work. This is exacerbated by

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7 However, the proposed reform of the nurses' grading systems, announced by the government in July 1999, includes the introduction of "nursing consultants" (Abrams, 1999). These would have a managerial role, but would also spend half of their time on the wards.

8 For an overview cf. Grauhan (1992), Wander (1992).

9 This was echoed by the director of nursing interviewed.

the fact that, in contrast to the medical director, the director of nursing often does not have an academic qualification[10]. Moreover, her/his position in the overall organisation of hospitals is fragile: nurses at ward level are not only accountable to the director of nursing, but also to doctors, who have the overall responsibility for the care of patients (Haug, 1995: 100). In addition, as there tends to be no middle management, the director of nursing has wide-ranging planning and decision-making powers, while the responsibilities of the ward are confined to performance and control. Consequently, the director of nursing services is constantly confronted with excessive demands, whereas staff at ward level are often excluded from decision-making (Gertz *et al.*, 1995). Although there have not been any major reforms of hospital management in recent years, its present professionally-based structure is challenged by pressures of cost containment and the introduction of funding based on diagnosis-related groups, which pushes for more efficient health care delivery. What is needed, it is emphasised, are not only professional qualifications, but increasingly also general managerial skills (Grigat, 1994; Haubrock, 1994). Against this background an argument is made for introducing a 'chief executive' (*Geschäftsführer/in*) to whom the present director of nursing services, medical director and chief administrator would be accountable[11]. The director of nursing interviewed pointed to another model of reform: the tripartite executive board would be replaced by a chief executive and consultants would have extended managerial responsibilities in relation to wards. There would be nurse managers at ward-level, who would be accountable to the relevant consultant.

In contrast, the management structures of community care providers are less complex, reflecting the smaller size of the organisational settings, as well as the minimalist regulatory framework at federal level. The provision for basic care is

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10 However, this might change in the future with degrees in nursing management becoming more widespread. For a more detailed discussion see chapter 8 on the governance of nursing education.

11 In recent years, this has indeed happened in some hospitals.

vague, stating that care has to be delivered under the supervision of an adequately qualified nurse (*ausgebildete Pflegefachkraft*). The requirements for medically-related care are more specific and far-reaching and prescribe that providers have to have a nurse manager (*Pflegedienstleiter/in*) as well as a chief administrator (*Geschäfsleiter/in*). As most providers deliver both types of community care, the second provision is most relevant.

Compared to the level of the provider, in both countries nurses are much less involved in the management of health care services at the level of purchasers: in Britain this is a result of the management reforms since the mid 1980s; in the German case it reflects the traditional dominance of the interests of employers and employees in the health insurance funds. In Britain, the involvement of nurses in health authorities/boards has undergone changes similar to those in provider organisations, although they have been more far-reaching. While directors of nursing are still part of the executive board, nursing posts at the level of the health boards, as a nursing and quality adviser of a health board pointed out, are purely advisory in their nature. Management responsibilities are confined to purely internal matters, such as quality and complaints. This was also reflected in the combined posts, which the two interviewees from the health board held. A nursing adviser/director of planning and development of a health board further explained that the credibility of nurses' involvement in health boards was no longer solely based on professional grounds and instead managerial skills as such had become more important. Also, as a nursing officer of the Scottish Office speculated, the future of these posts may be challenged by moves to further reduce the size of health boards.

In Germany, the insurance funds as purchasers have traditionally been dominated by the interests of employers and employees, whose contributions finance health care services. Furthermore, the fact that insurance funds are not involved in the provision of services has reinforced their focus on issues of finance and professional expertise has played a minor role. The only exception is the medical advice service of the insurance funds (*Medizinischer Dienst der Krankenkassen*). On request of the

insurance funds the medical advice service carries out medical assessments of patients who have been on long-term sick leave or who have applied for treatment in a spa. Following the introduction of the long-term insurance, the remit of the medical advice service has expanded to include assessments of the level of care dependency of patients who apply for benefits. As this is much more closely related to the expertise of nursing, the medical advice service has started to employ nurses[12]. But, as a senior nurse of a medical advice service explained, the involvement of nurses in assessing care needs is not clearly defined by the relevant guidelines. In practice, the role of nursing assessments is increasing, which reflects both their expertise and the high workload involved. Nevertheless, the medical advice service's strong legacy of a strictly medical orientation appears to prevail. A senior nurse of a medical advice service, for example, explained that nurses remain accountable to doctors. Here, she also pointed to the fact that care assessments are new territory for nurses, while doctors tend to have specialist qualifications, for example, in public health.

Discussion

The different importance attached to administering health services (centrally) is also reflected in the organisation of managing nursing services and the actors involved. In Britain, this is part of a highly vertically integrated structure of health administration. Until the mid 1980s the involvement of nurses in management was based on professional background and therefore *de facto* guaranteed. This has changed with the emphasis on general management, also allowing more scope for decisions at local level. Nevertheless, central government has retained the control in terms of structuring the management of health services. Considering the more decentralised nature of health governance in Germany, the regulatory framework of the management of nursing services is more fragmented. It combines state legislation and guidelines by the umbrella organisations of non-profit providers (in the case of

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[12] For an overview cf. Meyer (1995), Serwe and Westerhoff (1995).

hospitals) and minimal provision by federal legislation (in the case of community care providers).

However, the approaches in both countries only provide a general framework and leave considerable scope to the local level. The interesting question is: what factors influence micro-politics? Here, the evidence from both countries points to the importance of structural factors and gender, in particular. In the case of Britain, the introduction of general management is often regarded as a loss for nursing. Some of the evidence from the literature and the interviews, however, suggests that the professionally-based management hierarchy did not necessarily change the nature of the decision-making processes. Instead, existing power relations, such as those between nurses and doctors, remained intact. Moreover, the effect of the reforms on nursing has been quite mixed, varying between different management hierarchies. What has changed is perhaps not primarily the influence of nurses, but the nature of managing nursing services. The doubts about the *a priori* merits of professionally-based management structures are also supported by the German case. Although the director of nursing is part of a tripartite executive board, her/his position tends to be weak compared with the medical director and the general administrator. Thus, beyond the importance of the wider institutional framework and micro-politics, the evidence from both countries points to the importance of structural factors for understanding the management of nursing services. These are the low status of nursing care in health provision, vis-à-vis both medical practice and, more recently, managerial concerns about cost efficiency and containment.

10 Nursing and the division of labour in health care

Underlying the analysis of nursing and the governance of the division of labour in health care is the notion that what nursing is and what it does can be understood in terms of boundaries, both between different groups within nursing and between nursing and other health occupations. What nurses do is also about what they do not do. At the same time, the focus on intra and inter-occupational boundaries stresses the fact that the division of labour in health care is more complex than the notion of medical dominance suggests and that nursing itself is a highly heterogeneous occupation. The notion of boundaries is closely related to the neo-Weberian understanding of occupations in terms of social closure. However, it is problematic not only in conceptual terms[1], but also when the increasing blurring between different sectors of health care delivery, as well as the explicit emphasis on co-operation between different agencies and occupations, is considered. Even if it is difficult to define and locate boundaries, they may remain relevant in terms of occupations' perception of their practice and how they define themselves. An indication is the fact that the policy-driven emphasis on inter-sectoral and inter-occupational co-operation frequently provokes occupational turf battles about the demarcation of occupational territory[2]. The concept of "boundaries" and the governance of the division of labour, therefore, is central in policy terms.

The division of labour in health care comprises a myriad of relationships between different groups within nursing and between nursing and other health occupations. This chapter focuses on two classic examples of the governance of the intra and inter-occupational division of labour, notably between qualified and non-qualified nursing staff and between doctors and nurses. It is argued that micro-politics is the dominant mode of occupational governance, as the formalisation via credentialism and

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1 For a more detailed discussion see chapter 1 on theories of professions.

2 For a more detailed discussion of the issue cf. Beattie (1995).

legalism is weak[3]. But at the same time, micro-politics is contingent with other factors, such as types of work setting, situational and individual factors and particularly gender in the case of the division of labour between nurses and doctors.

Qualified and non-qualified nursing staff

The governance of the division of labour between qualified and non-qualified nursing staff is a salient issue[4]. From the perspective of qualified nurses the service contribution of auxiliary staff challenges the image of care as a 'professional' activity (cf. Thornley, 1996). However, the two are intertwined as the uncertainty of the role of unqualified staff reflects the lack of clarity of what (qualified) nursing is; it often consists of "being there", that is meeting any need occurring in a particular situation (Davies, 1995: 90f). At the same time, the prominence of the new nursing paradigm with its emphasis on academically-based care planning pushes for a clearer distinction between the areas of practice of differently qualified nursing staff (cf. Robinson, 1992). Moreover, the governance of the division of labour between qualified and non-qualified nursing staff has become more prominent in the context of current health policies in Britain and Germany. Their concern for cost efficiency and containment prompts a 'planned' as opposed to an 'accidental' mix of nursing staff (Alber, 1990: 341; Beardshaw and Robinson, 1990: 33f) and presupposes a clearer distinction between the two. Thus, the governance of the division of labour between qualified and non-qualified nursing staff is central from both managerial and professional perspectives.

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3 On the notion of credentialism see Collins (1979).

4 The terms "qualified" and "non-qualified" are different points on a continuum of different levels of training. Here, the main difference is that not all training leads to formally recognised qualifications *in nursing*. In Germany, the situation is further complicated by the fact that only staff with three years of training are considered as "qualified" (*examiniert*). Thus, although enrolled nurses with one year of training have a nursing qualification, they are not treated as "qualified". This section focuses on the distinction between "qualified" and "non-qualified" as it is most easily detectable.

In the following, approaches to governing the division of labour between qualified and non-qualified nursing staff are analysed. It is argued that governance by credentialism, that is by formalising scopes of practice through education, is limited. Instead, it is suggested that governance largely consists of micro-politics, although it needs to be viewed in the context of health policy initiatives from the centre. Here, there are moves both to redefine the division of labour, with greater scope being given to non-qualified nursing staff, and to define more clearly what the contribution of qualified nursing staff is.

In Britain, the education and practice of qualified nurses is regulated by United Kingdom Council for Nursing, Health Visiting and Midwifery (UKCC), whereas the curricula themselves are approved and monitored by the National Boards[5]. The UKCC's Code of Conduct provides some link between education and practice. Its 1992 revised version is based on individual judgements rather than rules and states that "... it is the Council's principles for practice rather than certificates for tasks which should form the basis for adjustments to the scope of practice" (UKCC, 1992: 9). The relationship between qualified and non-qualified nursing staff itself is based on delegation, with the former retaining overall responsibility (UKCC, 1992: 13). While the code allows considerable scope for the role of qualified nursing staff, the fact that the UKCC's remit (and thereby registration) is restricted to qualified nurses, provides a clear distinction vis-à-vis non-qualified nursing staff. Against this background a nursing officer of the Scottish Office regarded the regulatory framework of the UKCC as a safeguard against the dilution of nursing skills. It could be argued that this has been enhanced by the reforms following Project 2000, which introduced a single-level qualification by phasing out the qualification of enrolled nurses. At the same time, non-qualified nursing staff have been integrated into the credentialist strategy, as formal qualifications of health care assistants are now offered as part of the scheme of vocational qualifications. In some ways this helps to

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5 For a more detailed discussion see chapter 8 on the governance of nursing education.

identify more clearly the territory of qualified and non-qualified nursing staff: the "... introduction of the support worker grade ... (re-divides) nursing labour between the stages of the nursing process with professional nurses being responsible for care planning, while support workers undertake its delivery" (Draper, 1990: 360)[6]. On the other hand it may also become more difficult to distinguish between the scope of practice of qualified and non-qualified nursing staff: "Having had some training, the roles are more ambiguous now than before as the HCAs (health care assistants) are no longer untrained carers but nor are they qualified staff" (Workman, 1996: 612). This may entail health care assistants taking on tasks formerly delivered by qualified nursing staff, as an officer of the National Board and a nursing and quality adviser of a health board pointed out. Here, Ramprogus (1995: 143) also indicates that the territory of health care assistants is not specified and it is likely, therefore, to follow *ad hoc* service needs, negotiated at local level[7]. Thus, the role of credentialist strategies appears to be limited (or ambiguous at best). This is exacerbated by the current dynamics of health care, which seem to push towards a review of existing mixes of grades.

Looking at the context of health policy, the governance of the division of labour between qualified and non-qualified nursing staff has received new impetus through the internal market[8]. Inherent in the purchaser-provider split are pressures to meet increasing demand by providing health care services more efficiently. Since personnel costs account for the majority of the NHS expenditure, reviews of grade-mixes have been put on the agenda of providers (Buchan and Seccombe, 1993: 183). Thus, a nursing and quality adviser of a health board identified financial pressures as

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6 This interpretation of developments suits not only managerial concerns about simultaneously addressing manpower and cost issues (Naish, 1993: 25), but also the interests of the 'professional élite' in a clear demarcation between qualified and non-qualified nursing work (Draper, 1990). This last point was echoed by an officer of the Royal College of Nursing, who pointed to his organisation's main concern about the adequate training of health care assistants.

7 Moreover, the training of health care assistants is outside the remit of the UKCC and an officer of the National Board stressed the need for the National Board to exert some influence.

8 For an overview of historical and current dynamics of nursing auxiliaries cf. Edwards (1997).

the main force driving reviews of grade-mixes and existing divisions of labour. These pressures push nursing to more clearly define its role in the provision of services. This in turn presupposes a clearer definition of the scope of practice of non-qualified nursing staff. The centralist pressures in terms of funding and efficiency savings coincide with the emphasis on locally-tailored service provision, as reflected in the creation of independent trusts. More specifically, the "... devolution to unit level of many aspects of the personnel function is a central theme of the NHS White Paper" (Buchan, 1992: 22). Thus, while the pressure to re-address the division of labour comes from the centre, the way in which this is achieved is largely left to the local level. This coincides with the introduction of supernumerary status for nursing students, which has in effect reduced the nursing work force, and of formal qualifications for health care assistants. The pressure is two-fold: to review the grade-mix and the division of labour between qualified and non-qualified nursing staff, with a potential expansion of the scope of the latter (cf. Thornley, 1996: 170f). Here, several interviewees pointed to the increasing importance of support workers. But a nursing and quality adviser of a health board felt that the changes in Scotland were less significant as compared to those in England. Moreover, a nursing officer of the Scottish Office argued that there are limits to the substitution of qualified nursing staff with health care assistants: while they are cheaper to employ and more flexible as generic workers, the delivery of highly specialised and care-intensive services requires advanced levels of training.

In Germany, too, credentialism only plays a limited role in the governance of the division of labour between qualified and non-qualified nursing staff. Legislation at federal level provides a general framework for nursing qualifications, although there is considerable scope for the variation of curricula at local level[9]. As the regulatory framework only protects occupational titles, it does not draw a clear connection between education and the scope of practice (Dielmann, 1990: 34). Curricula only

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[9] For a more detailed discussion see the chapter 8 on the governance of nursing education.

provide an approximation of the territory of qualified nurses. The role of credentialism is further limited by the fact that there is a separate grade for enrolled nurses (*Krankenpflegehelfer/in*). Although this type of staff is not considered as "qualified" (*examiniert*), their formal training and recognised qualification blurs the distinction between qualified and non-qualified nursing staff. The governance of the division of labour between qualified and non-qualified staff is also influenced by the macro-context of health policy initiatives. As part of the 1993 health care reform the financing of hospitals has shifted from the "*Selbstkostendeckungsprinzip*", whereby the insurance funds met all of a year's expenditure, to the gradual implementation of specific charges and diagnosis-related groups[10]. As a result, there are now strong incentives to reduce the length of stay in hospitals. Combined with capped budgets, this has increased pressures in terms of cost containment and efficiency. In conjunction with the reform of the financing of hospitals a new formula to calculate staffing levels was introduced, the so-called "*Pflegepersonalregelung*". Its potential significance for nursing is two-fold: as part of drawing up a catalogue of charges, the scope of (qualified) nursing has to be defined. This also provides an opportunity to draw clearer boundaries vis-à-vis both non-qualified (nursing) staff and doctors (Gratias, 1994), a point which was also stressed by an officer of a trade union and a director of nursing of a hospital. Equally, this was encouraged by the requirement that permanent posts had to be filled with qualified staff and by the distinction between general and specific medically-related care[11].

There are interesting moves to adopt a more legalistic (and formalised) approach to the governance of the division of labour as part of the introduction of the long-term care insurance. As it co-exists with the statutory health insurance, a (legal) distinction was introduced between basic (*Grundpflege*) and medically-related care

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10 For an overview of the implications of the reform on hospitals cf. Beske (1993), Buck and Schlüntz (1994).

11 In the face of the considerable financial implications of increasing staffing levels, the new formula was stopped in 1997.

(*Behandlungspflege*)[12]. In part, it formalises the division of labour between qualified and non-qualified staff, as medically-related care is restricted to qualified nursing staff[13]. The distinction between basic and medically-related care is further specified as part of the general contracts (*Rahmenverträge*) between provider organisations and insurance funds. However, as an officer of a long-term insurance fund explained, it remains ambiguous, such as in the case of administering medication. This has led to further specifications by the health and long-term care insurance funds at federal level. But the decision-making process is highly controversial, as the distinction has potentially far-reaching financial implications. Considering the surpluses of the long-term care insurance and the pressures to contain expenditure, there have been moves to extend the scope of basic care. However, the distinction remains problematic from the perspective of providers, as the fees for basic care are lower. The governance of the division of labour between qualified and non-qualified nursing staff in community care, therefore, is characterised by a combination of legalism and self-administration. Nevertheless, there is likely to exist a considerable role for micro-politics, as the relevant provisions only define what non-qualified staff *cannot* do. Moreover, considering the financial pressures they are confronted with, providers are likely to be pushed to use any scope they have, as an officer of an umbrella organisation of community care providers observed. This is facilitated by the fact that the legal requirements in relation to grade-mix only set basic standards.

Nurses and doctors

Following a feminist analysis, the division of labour between doctors and nurses is understood to be governed by gender: "Historically, the gender composition of health occupations has proved a powerful factor in shaping patterns of inter-occupational dominance and subordination" (Witz, 1994: 37). Indeed, it is regarded as a classic

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12 For an overview of the provisions of the long-term care insurance see Meyer (1996).

13 However, the care delivery of non-qualified staff has to be supervised by qualified nursing staff.

example of the gendered division of labour in health care (cf. Davies, 1992; Perry, 1992). At a general level it manifests itself, for example, in the fact that health care is predominantly defined as medical care and it is also reflected in the dominance of hospitals in the provision of health care. Although the ultimate dominance of doctors vis-à-vis nurses has not been questioned, the underlying assumption of a homogenous division of labour has been criticised (cf. Hughes, 1988). Instead, different work settings and situational, as well as individual, factors have been identified as important influences on the governance of the division of labour between nurses and doctors.

In the following, it is argued that in both countries credentialist and legalistic formalisation play a subordinate role in the governance of the division of labour between nurses and doctors. Instead, it is subject to micro-politics at the level of individual providers and wards/teams. However, it is structured not only by gender, but also by other factors. The case of community care highlights not only the importance of work settings, but also the influence of policy initiatives from the centre. While in Britain recent changes seem to have strengthened the role of GPs, in Germany the introduction of the long-term care insurance has helped to define more clearly the territory in which community nurses can practise independently.

As discussed in the previous section, in Britain credentialism gives little indication of the exact scope of practice of qualified nursing staff. Similarly, there are no legal provisions and instead the setting of guidelines is devolved to local level (Haug, 1995: 48). McKnee and Lessof (1992), for example, point to a health circular following on from the Briggs Report. It asked health authorities "... to review areas of clinical activity in which delegation to nurses would be desirable. The tone of the circular nevertheless supported a dominant role for medicine, using terms such as delegation and stressing the need for a clearly defined policy agreed with doctors" (McKnee and Lessof, 1992: 63). However, Haug (1995: 49f) observes that there are few guidelines at hospital level and that the division of labour is therefore primarily

determined informally. The only legally codified limit to the role of nurses is prescribing, which is the prerogative of doctors[14].

However, the negotiation of the division of labour between doctors and nursing does not take place in a vacuum. Instead, gender is often seen to be one the most important forces structuring decision-making at local level, with doctors assuming a dominant position (cf. Campbell-Heider and Pollock, 1987; Menter Katzmann and Roberts, 1988; Porter, 1992). But the governance of gender is a contingent phenomenon and the degree of dominance varies. In a classic study, Stein (1978) observes that the relationship between doctors and nurses is not necessarily one of unproblematic subordination. Instead, he points to the "doctor-nurse-game", whereby nurses give doctors advice covertly, in order not to openly question medical dominance[15]. More recently, Porter (1995) suggests that the relationship between doctors and nurses has even become more egalitarian. Further, gender seems to co-exist with other forms of governance, notably organisational, situational and individual factors (Porter 1995). Porter (1991) and Hughes (1988), for example, suggest that interaction between nurses and doctors is influenced considerably by different types of wards, the corresponding reliance on medical technology and the status and/or experience of individual doctors and nurses[16]. Hughes (1988: 16), for example, concludes from his analysis of casualty departments that the "... heavy work demands associated with the 'sorting' function of the casualty department, the potential urgency of treatment, and the short-term nature of most medical appointments all increase nurse influence". Here, he also points to the special relationship between nurses and overseas doctors.

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14 However, the role of nurses in prescribing is being reviewed. For a more detailed discussion see McKnee and Lessof (1992: 63ff).

15 The level of complexity is also reflected in the different types of relationships involved, with nurses not only taking on medical tasks ('subdoctoring'), but also providing caring tasks in their own right (Walby and Greenwell, 1994: 21). From the medical point of view the first case, that is an expanded role of nurses, is desirable, while the second case, that is any extension of the scope of nurses' practice, challenges medical dominance.

16 Similarly Walby and Greenwell (1994), Mackay (1993).

Similar to Britain, credentialism plays a subordinate role in the governance of the division of labour between doctors and nurses in Germany. The same is true for legalism: as the relevant provisions confer far-reaching powers to doctors, the relevant legislation (*Sozialgesetzbuch V*) defines health care as all those activities which doctors consider necessary to meet a patient's health needs. Nursing care, then, is seen as a delegated activity based on medical decisions, but it is not acknowledged in its own right (Böhme, 1990). The relationship between nurses and doctors is based on delegation: doctors retain the overall responsibility ('responsibility of delegation'; *Anordnungsverantwortung*), while nurses only assume responsibility for the delivery of the task (*Durchführungsverantwortung*) (Dielmann, 1990: 34f). While these provisions leave little doubt about medical dominance, they do not say anything about the division of labour between nurses and doctors itself. From a legal point of view, any (medical) tasks can be delegated to nurses (Dielmann, 1990: 35). Thus, the formalisation of the division of labour between doctors and nurses is minimal (Lilie, 1985: 458). Here, Haug (1995: 41) argues that this reflects the fact that the core of each occupation's territory is not contested: as little as doctors would be expected to make patients' beds, as unlikely is it that nurses would be asked to perform operations. Thus, only overlapping tasks are subject to controversy, with the giving of injections being the most prominent example. Against this background, Haug (1995: 47) concludes that the division of labour between nurses and doctors is primarily subject to micro-politics and varies between different hospitals and types of wards.

But the influence of organisational, situational and individual factors is embedded in the gendered nature of the division of labour between nurses and doctors. This manifests itself in the fact, for example, that the practice of nurses has been strongly influenced by the development of medical practice. With its increasing specialisation nurses have become more involved in assisting doctors in performing 'technical' tasks. Although this has extended the role of hospital nursing in a vertical direction (Haug, 1995: 163f), it has not necessarily altered the subordination of nurses to doctors. On the contrary, by entering the medical domain ('sub doctoring') nurses'

dependence on doctors has even increased[17]. Empirical studies also show that the amount of medically-related care has considerably expanded and that it is often given priority over basic care, which is concerned with the physical/psychological well-being of patients (Riedel and Steininger, 1992: 18ff).

While the governance of the division of labour between doctors and nurses in community care is broadly similar, there are interesting differences pointing to the importance of different work settings. Here, interactions between doctors and nurses are not only much less frequent and concentrated in spatial terms, but also of a different nature as the medical model of cure is less strong[18]. At the same time, recent changes in both countries also point to the importance of policy initiatives from the centre in structuring decision-making at local level, particularly in terms of the balance of power between doctors and nurses. In the context of Britain, health policy initiatives since the early 1990s have strengthened not only the role of primary care, but also the position of GPs[19]. With the internal market the majority of GPs have become fundholders and their purchasing power has been extended to include community nursing services.

Although nurses are still employed by separate provider units their practice is now potentially subject to greater influence by GPs. Here, a nursing officer of the Scottish Office felt that a primary care-led NHS may be dominated by GPs, as the purchasing function assumes that they define patients' nursing care needs. In contrast, an officer of the National Board and a director of nursing/general manager were more

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17 Here, a professor of nursing pointed to the challenge posed by nursing models. Instead of 'sub-doctoring' they focus on nursing as a therapy in its own right and thereby challenge the dominance of doctors.

18 This goes back to Johnson's (1972) argument about the degree of indeterminacy of the relationship between patients and doctors. It is higher in non-hospital settings, which tend to deal with non-acute illnesses. In these cases the applicability of the bio-medical model of health and illness is limited.

19 The thrust of these developments is the emergence of the concept of a primary care-led NHS (cf. NHS Executive, 1996).

optimistic. The latter argued that while GPs hold the contracts, they do not control what community nurses do; particularly as they work in self-managed teams. In addition, following the new contract in 1990, GPs began to employ their 'own' practice nurses, whose numbers and scope have increased and whose work partly overlaps with the work of community nurses (Lightfoot *et al.*, 1992: 26). Against this background, Witz (1994: 36f), for example, observes that "... the recent introduction of GP contracts has led to GP-centric realisation of the increasing emphasis on health promotion in British health policy, and so mitigated against the realisation of health promotion models that envisaged an enhanced, community nurse, or nurse practitioner roles as the linchpin of primary care initiatives".

In comparison, the introduction of the long-term care insurance in Germany seems to have helped to define more clearly that part of the territory of community nurses where they can practice independently of office-based doctors (Igl, 1995). Prior to the long-term care insurance, it was the sole responsibility of office-based doctors to assess the (community) care needs of patients and to decide whether to delegate the delivery of the hands-on-care to community nurses[20]. As a result, they had considerable influence in determining the division of labour between them and community nurses. In part, this has changed with the introduction of the long-term care insurance, which has shifted governance from medical dominance to legalism, and (joint) self-administration of insurance funds and providers. While the delivery of medically-related care, financed by the health insurance, continues to depend on medical delegation, the delivery of the new type of basic care is based on legal/contractual provisions: the relevant legalisation (*Sozialgesetzbuch XI*) sets out the types of tasks covered, which are further specified by lists of charges (Faber, 1994: 26). But as patients tend to need both types of care the independent territory of nurses is limited. Further, the distinction between basic and medically-related care remains ambiguous, as a senior nursing officer of a medical advice service stressed.

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[20] For an overview cf. Böhme (1993).

Nevertheless, with the notion of "basic care" the long-term care insurance has created an 'occupational territory', which is exclusive to nurses, and in which they can act independently (Gaschler, 1995; Höhmann, 1995).

Discussion

The analysis of the governance of the division of labour between qualified and non-qualified nursing staff and between nurses and doctors suggests that micro-politics plays a central role, as the scope of formalisation via credentialism and legalism is limited. In both countries, education helps little to define occupational territories. In the case of Britain, the connection between education and practice is explicitly subject to the individual judgement of nurses. Any demarcation has also become potentially more difficult with the introduction of formal training for non-qualified nursing staff. Further, with the exception of prescribing, no legal provisions exist. In part, the role of micro-politics has also been strengthened by the introduction of the internal market.

The situation in Germany is similar: education legislation protects occupational titles, but not the scope of practice. Moreover, as in the case of Britain, non-qualified nursing staff receive formal training. Similarly, the legislative framework regulating the provision of health care makes the division of labour between nurses and doctors subject to medical decisions. However, there have been interesting developments in the context of community care, where the institutionally-based distinction between different types of care has helped to define more clearly the territory of (qualified) nurses. But the governance by legalism (formalisation) is limited, as the distinction between these two types of care is ambiguous. Thus, there remains considerable scope for micro-politics, particularly in the case of qualified and non-qualified nursing staff.

11 The occupational governance of nursing in a comparative perspective

The preceding chapters analysed the occupational governance of nursing in Britain and Germany, and its central dimensions: health governance, education, the management of nursing services and the division of labour. Adopting a macro-perspective the analysis examined how governance is organised and which actors are involved. The underlying questions were how nursing as an occupation is governed and how this is influenced by the institutional context of health care in each country. The findings of the analysis can be summarised as follows:

Figure 11.1: The occupational governance of nursing in a comparative perspective

dimensions of occupational governance	Britain	Germany
health governance	national health service, operated on basis of public contract model	social insurance system
	key role of central government	limited and mainly regulatory role of federal government
	purchasers and providers negotiate contracts at local level	joint self-administration between insurance funds and providers
	institutionalised medical dominance	institutionalised medical dominance
	role of nursing is uncertain	nursing is marginalised
nursing education	statutory self-regulation by professional bodies	fragmented legalism
	two-tiered regulatory framework with extensive scope	limited scope of federal legislation, patchy legislation at state level
	regulatory bodies as "countervailing power"	leaves considerable scope for (localised) self-regulation by employers
managing nursing services	highly vertically integrated health administration provides framework	federal legislation is limited, co-exists with self-regulation by provider organisations
	leaves extensive scope for micro-politics	leaves extensive scope for micro-politics
	role of nursing uncertain due to general management and gendered nature of care	influence of nurse managers uncertain due to gendered nature of care
division of labour	formalisation by credentialism is weak, hardly any legal provisions	formalisation by credentialism is weak, legal provisions exist, but remain general
	importance of micro-politics, which is contingent upon gender, work setting, situational and individual factors	importance of micro-politics, which is contingent upon gender, work setting, situational and individual factors
	influence of nurses is variable	influence of nurses is variable

By way of a summary, this chapter provides a more systematic analysis of different modes and levels of governance and the differences and similarities between Britain and Germany. The chapter concludes by discussing some methodological implications of the analysis.

Comparing and contrasting modes of governance

On the basis of the analysis, an initial distinction can be drawn between different modes of governance: legalism, credentialism, self-regulation and micro-politics. They describe different ways of governing nursing and have important implications not only for the levels of governance, as discussed later, but also for the actors involved.

Legalism is particularly prominent in the case of Germany. By way of formal provisions it sets out (basic) standards, which apply to the actors at local level. This implies a certain degree of uniformity. But the governing power of legalism can be constrained by the limited scope of the relevant legal provisions (as in the case of the management of nursing services) or by fragmentation across different levels of governance (as in the case of nursing education). Similarly, as the example of the division of labour shows, legal provisions remain general and exist side-by-side with decisions made by local actors. In short, legalism consists of setting standards which formalise decisions by the actors involved in governing nursing. The nature of credentialism is similar, in that training may help to define the occupational territory of nursing and the division of labour in health care, both between nursing staff with different levels of training and between nurses and doctors. Here, the underlying assumption is that training provides skills and that skills largely determine what occupations do. However, the analysis of the division of labour in the British case, for example, stresses that the definition of skills is not only highly politicised, but that training does not always clearly define boundaries. On the contrary, as the debate about health care assistants indicates, training might even blur occupational territories and boundaries may primarily be decided at local level.

Legalism and credentialism, therefore, point to the potentials and limits of formalising the process of governing nursing. In contrast, self-regulation and micro-politics as the other two modes of governance are more dynamic in their nature, as they are based on the activities of specific actors. Self-regulation describes governance organised collectively around a particular actor, giving it a prominent role in the process of governing. In the case of nursing education and the management of nursing services in Germany, for example, self-regulation by providers plays an important role. But self-regulation not only privileges one actor over others, it also implies a certain degree of independence from the state. However, in the case of statutory self-regulation, for example in the case of nursing education in Britain, the initial prerogative has been granted by the state. Whereas self-regulation presupposes some collective organisation of the actors concerned, the dynamics of micro-politics are more spontaneous. Micro-politics refers to decisions taken by actors at local level. These might be local providers of services, managers or doctors and nurses as frontline-practioners. Also, micro-politics is more dependent on individuals, for example, the negotiation of the division of labour between doctors and nurses on a ward. While this mode of governance is likely to be more *ad hoc*, it is nevertheless contingent on various factors, particularly gender and work-setting.

In summary, although there are different modes of governance, they tend to operate in conjunction with each other. For example, in both countries the division of labour is subject to a combination of limited governance by credentialism and legalism on the one hand, and governance by micro-politics on the other. Or to put it differently: because credentialism and legalism are weak, micro-politics is strong. Similarly, the type of governance also has implications for the actors involved and the balance of power between them. In the case of the governance of nursing education, for example, in Britain statutory self-regulation by professional bodies means that nursing plays a central role. In Germany, in contrast, fragmented legalism allows for employers to exert considerable influence, while the role for nursing remains uncertain.

Comparing and contrasting levels of governance

The comparison of different dimensions of the occupational governance of nursing highlights the prominent role played by micro-politics, particularly in the management of nursing services and the governance of the division of labour. This not only challenges the usefulness of the macro-perspective for understanding the occupational governance of nursing, but also raises more general issues about the relationship between governance at micro and macro level. It also begs the question as to whether certain dimensions of occupational governance are more likely to be governed by micro-politics than others. The discussion suggests that this may be the case, but that the governance at micro level is also intertwined with macro modes of governance, as well as with policy initiatives from the centre.

In some ways, the prominent role played by micro-politics is not surprising. Irrespective of the scope and cohesiveness of legalism or statutory self-regulation, as macro modes of governance, they have to be implemented by actors at local level. It is local nursing colleges, for example, which design curricula, provide classroom-based teaching and arrange work experience. Nevertheless, there are differences in terms of degree and micro-politics seems to be particularly important for the management of nursing services and the division of labour. It could be argued that these deal with highly local agendas, in that they are concerned with managing nursing services in a *specific* hospital or with the allocation of work on a *specific* ward or in a *specific* community nursing team. Micro-politics, then, may be understood as the contingent coming together of individuals in a local setting. But the balance of power between the actors involved is not necessarily arbitrary. Instead, it is structured by the type of work setting (for example hospital vs. community care; intensive care vs. general ward), by the situation in which an interaction occurs and by structural factors such as gender. The influence and role of nursing in occupational governance is thus variable, as in the case of the division of labour in both countries, or even uncertain, as in the case of the management of nursing services in Britain.

But the prominence of micro-politics may not only reflect the nature of certain dimensions of governance, it may also be the corollary of a macro mode of governance. For example, in the case of Germany and the division of labour in community care the legal provisions only set basic standards, which in effect devolve considerable power to the local provider. Similarly, micro-politics may be part and parcel of a macro-led mode of governance. In the context of the introduction of the internal market in Britain, for example, local purchaser and provider organisations were given greater freedom in terms of how to organise their services, including management structures. At the same time, they remain firmly embedded in a highly vertically integrated structure of health administration, with funding and the parameters of service being controlled by central government. This example also points to the fact that the governance at micro level can be subject to pressures from policies by the centre. Although in Britain the division of labour between qualified and non-qualified nursing staff is entirely left to local providers, the emphasis of central government on cost efficiency (in conjunction with the introduction of training for health care assistants) seems to have encouraged a greater reliance on non-qualified nursing staff. Similarly, in the case of Germany and the division of labour between qualified and non-qualified nursing staff in community care, the scope of local providers is curtailed by the tight financial limits of the (health and) long-term care insurance.

Comparing and contrasting Britain and Germany

The analysis suggests that the occupational governance of nursing tends to be more cohesive in Britain, whereas it is more fragmented in Germany. This points to the influence of the differing characteristics of health governance in each country and the role of central/federal government more specifically. But in some ways the two countries have become more similar with the introduction of the public contract model in Britain in the early 1990s. This also has important implications for the influence of nursing in occupational governance.

In Britain, central government plays a powerful role in the governance of health care: it controls the funding of health care, it is the top tier of a highly vertically-integrated structure of health care administration and as such it sets the parameters for contracts and service provision at the local level. Further, it operates within a centralist and unitary state. The corollary is a greater potential to structure the occupational governance of nursing, which is not necessarily tantamount to state dominance. This capacity of the state is particularly relevant in the context of nursing, as it tends to be in a weak position compared to other actors, especially the medical profession. In the case of education, for example, central government set up a two-tiered framework of statutory self-regulation by professional bodies, which have an extensive remit. Similarly, following a professional and consensus-based approach, central government integrated nursing into the multi-tiered health care administration in the 1960s and 1970s. But the example of managing nursing services also points to changes in the approach taken by the state. Although it retains considerable influence, there is now more scope for local purchaser and provider organisations. The implications for the occupational governance of nursing are two-fold: it becomes more variable because it is subject to micro-politics, as the example of managing nursing services shows. Further, the role of nursing in purchaser-provider relationships is uncertain and the dominant agenda of cost efficiency reduces the likelihood of key actors addressing nursing issues. But equally, this may be counter-balanced by the increasing emphasis on quality assurance (cf. Alaszewski, 1995: 66f). Significantly, many nurses in management positions, for example, have a remit for quality issues.

In comparison, the role of the federal government in health governance in Germany is more limited. It is largely restricted to setting the legislative framework in which the joint self-administration of insurance funds and provider organisations operates. Nursing is not only physically excluded from these multiple forums of governance, but their preoccupation with cost containment makes it unlikely that any of the actors take an interest in nursing issues. Although recent years have seen the federal government adopting a more interventionist role, this substantive regulation has been

geared towards making the joint self-administration comply with the aim of cost containment and has not addressed its exclusiveness as such. However, the powers of the federal government are limited due to three factors: the extensive role of self-administration in health care; federalism; and the strong welfare-mix in the provision of health care. The second aspect is particularly relevant in the context of the occupational governance of nursing and its reliance on legalism. Here, the potential cohesiveness and centralism of legalism is weakened by the fact that the implementation is devolved to state level (in the case of education) or that its scope is limited (in the case of managing nursing services and the division of labour in community care). In turn, this makes the occupational governance of nursing more fragmented and it also allows for an extensive role for employers and provider organisations. As a result of its fragmented and decentralised nature, then, there are few countervailing powers in the occupational governance of nursing. These would be actors who had the interest and power to take on nursing issues and, thereby, to counterbalance the powerful interests of employers, insurance funds and the medical profession.

Methodological implications

The analysis of the occupational governance of nursing in Britain and Germany has stressed the interdependence between micro and macro level: while micro-politics at the level of individual provider organisations plays a central role, it cannot be understood in isolation from the macro-institutional contexts of health systems and the policy changes initiated by central/federal government. By the same token, an exclusive macro-perspective only partially captures the essence of the occupational governance of nursing, in which local actors are central.

In methodological terms, the analysis points to the need to adopt a multi-level approach. The limited scope of a macro-perspective is particularly apparent in the case of the governance of the division of labour. Whereas it is central for understanding the occupational governance of nursing, micro-politics is a blind-spot

of the macro-perspective. The macro-analysis is confined to speculation, for example about the impact of health care reform on individual providers. Similarly, understanding the occupational governance of nursing from a micro-perspective is limited. This manifests itself, for example, in the governance of the division of labour between qualified and non-qualified nursing staff in community care in Germany: while micro-politics plays an important role, it is embedded in a legal framework and it is subject to intense pressures of cost containment from the centre. The governance at local level can also be seen as a process of digesting macro-policies.

THE GOVERNANCE OF INTERNAL BOUNDARIES IN COMMUNITY NURSING

Chapters 7-11 analysed different aspects of the occupational governance of nursing in Britain and Germany. The underlying questions were how nursing as an occupation is governed, and how this is influenced by the institutional context of the respective health system. The analysis adopted a macro-perspective and paid particular attention to the actors involved and the institutional settings in which they operate. The conclusions emphasised the importance of micro-politics for understanding the occupational governance of nursing.

Against this background, the set of chapters that follow (chapters 12-16) present a case study of the occupational governance of internal boundaries in community nursing, adopting a micro-perspective. The underlying aim is to complement the macro-analysis of the occupational governance of nursing and to examine more closely the relationship between different levels of governance. Chapter 12 introduces the case study, arguing that it is interesting both from a theoretical and an empirical perspective. It goes on to define more closely community care in a comparative context. Chapters 13-15 analyse interview material collected in two localities in Britain and Germany. The concluding discussion (chapter 16) draws together the analysis of the different dimensions of the governance of internal boundaries.

12 Introducing the case study

The macro-analysis of the occupational governance of nursing and its different dimensions, highlighted a range of issues for potential case studies. This chapter makes a case for the analysis of the occupational governance of the internal boundaries in community nursing. It is argued that there are good theoretical and empirical reasons for focusing on internal boundaries: they are at the centre of the occupational governance of nursing and they have also become more prominent in the current context of health dynamics. Moreover, community care provides an interesting framework for the analysis, as the dual concern for cost efficiency/containment and service development has politicised internal boundaries.

At the same time, however, defining community care is difficult, especially in a comparative context. In part, this reflects overlapping institutional responsibilities as well as the multiple and scattered spaces in which community care is provided. But it also points to the marginal nature of community care compared to other areas of welfare provision. Although the political profile of community care has increased, definitional issues remain or have become even more complex. However, the analysis of nursing staff involved in the provision of community care indicates interesting differences. In Britain, care outside hospitals is largely in the hands of nurses with specific community-oriented qualifications, while the percentage of non-qualified staff is marginal. Almost the reverse is the case in Germany, where non-qualified staff play a significant role and where the majority of qualified staff either have general nursing or social care-oriented qualifications. In part, this reflects differences in the structure of nursing qualifications.

Theoretical and empirical reasons for studying internal boundaries

In different ways the occupational governance of nursing is concerned with defining what nursing is. Here, boundaries play a potentially important role, as they describe

the interface between nursing and other occupations, or between different groups within one occupation. In essence, boundaries are concerned with issues of the division of labour. Moreover, the focus on boundaries also highlights the fact that nursing does not exist on its own, but that it is part of, and shaped by, a given division of labour.

The importance of definitions and boundaries is echoed in the literature on theories of professions[1]. Indeed, the definition of professions is one of the literature's salient issues. The notion of occupational boundaries is particularly prominent in neo-Weberian theories of professions (cf. Parkin, 1979; Witz, 1992)[2]. Their discussion of different directions of social closure also gives some indication of different types of boundaries, notably between dominant and subordinate occupations (such as doctors and nurses) and between staff with different levels of training within the occupation itself (such as fully-qualified nurses and nursing auxiliaries). Along these dimensions the following types of boundaries can be identified:

Figure 12.1: Different types of occupational boundaries

	internal ***within one occupation***	**external** ***between two or more occupations***
horizontal ***comparable status/level of training***	between different specialities in nursing *for example, practice nurses and district nurses*	between nursing and other caring occupations *for example, health visitors and social workers*
vertical ***different status/level of training***	between nursing staff with different levels of training *for example, between fully-qualified nurse and nursing auxiliaries*	between nurses and doctors

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1 For a more detailed discussion see chapter 1 on understanding occupations comparatively.

2 Similarly, Abbott (1995) describes his notion of jurisdiction of work as a "theory of boundaries". It also highlights the contested nature of boundaries, described as a "turf-driven matter" between different occupations.

The figure points to different dimensions along which occupational boundaries can vary: they can describe the interface between different groups within one occupation (internal) or between two different occupations (external), or the interface between occupational groups with similar status/level of training (horizontal) or with a different status/level of training (vertical). The case study focuses on the vertical variant of internal boundaries. The analysis of this type of boundary is particularly interesting for empirical reasons, as the interface between nursing staff with different levels of training has become politicised in the context of current health policy initiatives in both countries. In what follows, for reasons of simplification, this vertical variant of internal boundaries is referred to as "internal boundaries". Internal boundaries become apparent and are subject to decisions in different situations: in the long-term they manifest themselves in decisions about the composition of nursing staff working in a team or in a ward, that is the mix of different levels of training. In contrast, in the medium- and short-term internal boundaries are highlighted by decisions about the division of labour between nursing staff. The occupational governance of internal boundaries, then, can be operationalised by focusing on certain types of *decisions* about nursing services.

It could be argued that by focusing on internal boundaries the case study is in danger of falling into the 'definitional trap' of mainstream theories of professions. As argued earlier, these tend to constrain rather than encourage the comparative analysis of nursing, as they are based on implicit assumptions about the generic nature of occupations and their relationship to the state[3]. However, the case study does not aim to locate and map out internal boundaries as such. Instead, it treats boundaries as an issue which is central to decision-making, without necessarily presupposing its relevance in terms of defining what nurses actually do[4]. It is concerned with the

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3 For a more detailed discussion see the review of theories of professions in chapter 1.

4 In some ways, this paraphrases Burrage *et al.*'s (1990) argument: although the concept of professions is problematic from an analytical point of view it remains an important point of reference for occupations themselves.

governance of internal boundaries. Thus, it focuses on decision-making processes and aims to understand the *process* of boundary-setting. This includes questions as to how boundaries are set and as to who is involved. Internal boundaries, then, provide the analytical framework for analysing the occupational governance of nursing in Britain and Germany from a micro-perspective.

So far, it has been argued that analysing the occupational governance of internal boundaries in community nursing is interesting for theoretical and analytical reasons. The case study takes the salient issue of internal boundaries as its starting-point and uses the issue as a framework to explore the nature of occupational governance, its institutions and actors as well as the relationship between macro and micro-governance. At the same time, there are also empirical reasons for the choice of case study. In Britain and Germany, recent health policy initiatives have challenged existing internal boundaries in nursing. The policy emphasis on cost efficiency and containment has politicised issues of governance, with personnel costs accounting for the majority of health care expenditure and with nursing being the single largest occupation in health care. In addition, the higher profile of internal boundaries has highlighted potential conflicts between professional and managerial agendas[5].

This problem is particularly well exemplified by the case of community care as it faces the challenge of squaring the circle between the perceived need for service development in the face of potentially increasing demands and the concern for cost containment/efficiency. In the context of her comparative analysis of domiciliary

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[5] However, in the context of the British debate, some authors suggest that these two sets of interests do not necessarily exclude each other " ... the uplifting and separation of an elite of clinical nurses from basic carers fits in broadly with a managerialist rationalization of the health service, in which 'skilled' workers will obtain higher rewards and autonomy, while basic care is generally cheapened" (Carpenter, 1993: 242). A possible explanation is that the pure professional model in which the support worker would free qualified nurses to concentrate on care (Jewett and Walton, 1994: 7) is not feasible in the current political climate as it would require an increase in the number of trained staff. The second best option, then, is to preserve a highly qualified elite by tolerating an increase in the number of support workers (Thornley, 1996).

care, Tester (1996: 76ff) distinguishes between different phases of policy development: she characterises policy development in the 1960s and early 1970s as "growth without explicit policies", where there was little policy response to the increased demand for care. As a result of changing attitudes to institutional care and alternative concepts of community care, the 1970s saw more policy initiatives. Finally, policy developments of the 1980s are labelled as "policies without growth", in that the need for developing community care was recognised, but considerably constrained by financial pressures. Thus, the debate about community care originated from a critique of institutional forms of care delivery. But it has received new impetus in the context of concerns about the implications of demographic and epidemiological changes, in terms of both the infrastructure and costs of service delivery. These changes are seen to increase the demand for care, especially in non-acute care settings[6]. This is echoed by the current trend towards de-hospitalisation, that is measures which aim to reduce the length of stay in hospitals, particularly in order to contain expenditure for acute care[7]. Paradoxically, then, the potential development of community care not only takes place in a general climate of financial austerity, but may itself become part of the efforts of cost efficiency/containment. In Britain, the development of existing community services culminated in the 1990 "NHS and Community Care Act" and it is argued that its aim was both to contain public expenditure and to improve access to home-based care (Wistow, 1995). Similarly, the newly introduced long-term care insurance in Germany only provides basic coverage to support informal care (cf. Böhme, 1995).

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6 For an overview of the debate cf. OECD (1996); for Britain cf. Lightfoot *et al.* (1992: 1), Rathwell and Godinho (1995: 3); for Germany cf. Bartholomeyczik *et al.* (1994: 10ff), Schaeffer *et al.* (1994a: 7ff).

7 For a more detailed discussion see the analysis of health governance in chapter 7.

Defining community care - understanding its dynamics

While its political profile has increased over recent years and while there may be some kind of agreement that "it is a good thing", community care is difficult to define. Its institutional make-up is complex, as it encompasses different locales of care delivery, ranging from residential to day and, increasingly, domiciliary care[8], as well as different user groups, ranging from families and the acutely ill, the elderly and physically disabled to the mentally ill and handicapped. Cross-cutting these axes are parallel structures of responsibility, that is between health authorities and local Social Services Departments in Britain and between the health and long-term care insurance schemes in Germany[9].

In part, this institutional complexity reflects the marginal nature of community care, as something which is 'left behind' by hospitals, because it does not fit into the (medical) model of acute care. At a general level, then, community care can be defined as care provided outside hospitals. But the comparison between Britain and Germany challenges the very term "community care". As Tester (1996: 5) points out, it strongly reflects the British debate over the last four decades, which equates community care with care in non-institutional settings. Here, the term "community" itself is also ambiguous, as it describes both the people living in a certain geographical area as well as a group of people with common features or interests[10]. In contrast, the German debate focuses on different types of care, which may be delivered in both residential and domiciliary settings: while health care is directed towards acute illness (*Krankheit*), long-term care addresses chronic illness (*Pflegebedürftigkeit*). This distinction reflects the dominance of the health insurance scheme and its medically-oriented outlook. It could be argued that the different

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8 In the following "domiciliary" refers to a specific care *setting*, that is home-based as opposed to residential care. In contrast, "domestic" is used to denote a specific *type* of care, notably household tasks.

9 In Scotland, these are referred to as Health Boards and Social Work Departments respectively.

10 For a more detailed discussion see Mayo (1994: chapter 2).

emphases of the British and German debate should also be reflected in the use of terminology. However, for reasons of simplicity, the term "community care" is used for both countries, notably in a generic way, describing care outside hospitals which may be residential or domiciliary. Moreover, rather than trying to do the impossible and to carve out a specific definition, in the following a dynamic perspective is adopted in order to map out the arena of care outside hospitals. With an eye to the focus of the case study discussed below, particular attention is paid to care in domiciliary settings.

In Britain, well into the 1960s (formal) non-acute care for the elderly and physically disabled and particularly for the mentally handicapped and ill was predominantly delivered in residential/institutional settings (cf. Lewis and Glennerster, 1996: 1f). This changed gradually with the closure of long-stay care wards in old hospitals and former workhouses as well as with policy initiatives which aimed at developing care in community settings[11]. The term community care, then, became a "... shorthand to refer to community-based services which provide an alternative to residential or institutional care" (Henwood, 1990: 18; similarly Lewis and Glennerster, 1996: 2). These moves reflected an emerging consensus that community-based care was more appropriate. It had been triggered by academic evidence of the failure of institutional care, coupled with pleas to reduce patients' dependency and for society to acknowledge the existence of these "Cinderella groups" of patients. At the same time, official enquiries pointed to the low standards of care in institutions. But the broad consensus that "community care is generally a good thing" did not necessarily materialise in concrete policy terms, as reflected in the ongoing and recurring nature of the debate on community care (cf. Ham, 1992: 74ff, Henwood, 1990: 18f). Similarly, Walker (1993: 205) asserts that the consensus in community care has been rather precarious "... relying on ambiguity and uncertainty of purpose in policy and absence of strategic planning". Thus, compared with other areas of the welfare state

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[11] For an overview of the different policy initiatives cf. Ham (1992: 74ff).

the development of community care is often seen as a "history of neglect" (Means and Smith, 1994)[12].

Against this background the strong policy emphasis on community care in recent years, as reflected in the 1990 NHS and Community Care Act, appears surprising[13]. Here, Means and Smith (1994: 45) suggest that the higher political visibility of these debates can be explained by policy makers' concern about "... the cost of existing (in this case institutional) provision because of demographic and other trends". The perception of community-based care as a cheaper option became more important in the context of increasing concern about welfare expenditure in the 1970s and 1980s (Baggot, 1998: 229). This appeared to be particularly relevant for the services of the elderly, where the demand for care was likely to rise in the future as a result of demographic/epidemiological changes and the reduction of long-term care facilities in hospitals (de-hospitalisation). The dual but contradictory challenge, then, is to meet potentially-increasing demands without necessarily raising public expenditure (Wistow, 1995: 228). This is reflected in yet another re-definition of community care, with more explicit emphasis being put on informal care, that is on care *by* the community (cf. Land, 1991: 209f; Walker, 1993: 206)[14].

Any definition of community care is also made difficult because of the complexity and even fragmentation of institutional structures (Land, 1991: 208). Here, a central

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12 Means and Smith (1994: 34ff) discuss possible explanations for this neglect: following a political economy approach it could be argued that the people needing community care belong to the weakest groups in society, in that they do not (and cannot) actively take part in the capitalist mode of production and, therefore, structurally depend on the state. This is echoed by negative cultural stereotypes about ageing and disability. Alternatively, it is suggested that the institutions of community care are designed to impose a stigma on its users, in order to discourage its use. Similarly, governments might fear that extensive public funding of community care would undermine informal care arrangements. For a similar discussion with reference to personal social services cf. Adams (1996).

13 For an overview of the origins of the 1990 reform cf. Lewis and Glennerster (1996: 2ff), Means and Smith (1994: 56ff).

14 As an early example of this kind of thinking Henwood (1990: 18) refers to the 1981 White Paper "Growing Older" which envisages the role of public services to be an enabling one "... helping people to care for themselves and their families by providing a framework of support".

feature is the complex division between health and social care, which goes back to the evolution of parallel structures after the Second World War[15]. Following the 1990 NHS and Community Care Act, community care has shifted from health to social care (Means and Smith, 1994: 157)[16] and local authorities were given the "lead responsibility". As such they are required to prepare community care plans in association with health authorities and other agencies (cf. Ham, 1992: 53; Lewis and Glennerster, 1996: 167). Thus, the interface and, ultimately, the co-operation between different agencies and occupations has become more important: "The ambition is hardly new, but the emphasis in the 1990s on making services more responsive to users' needs has resulted in a new push for collaboration" (Lewis and Glennerster, 1996: 165)[17]. At the same time, collaboration may also have become more difficult, considering the internal market's emphasis on competition (rather than collaboration) and the tight budgetary restrictions of both health and local authorities. Moreover, the demarcation between the two has remained disputed and there still exist considerable overlaps (Means and Smith, 1994: 147). In the case of domiciliary care, for example, the work of social service home helps has extended to include personal social services (such as bathing or dressing), overlapping with the practice of district nurses (cf. Henwood, 1992: 21; Means and Smith, 1994: 149; Nazarko, 1995)[18].

At the same time, the relationships within community health care itself and the basic model of health authorities purchasing community care and trusts providing it, has become more complex. As the internal market has evolved, hospitals are reaching out

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15 For an overview cf. Glendinning (1998), Hugman (1995: 33f), Lewis and Glennerster (1996: 166), Means and Smith (1994: 143ff).

16 Ultimately, this reflects a covert shift of the responsibility for long-term care to users and their families, as social care can be charged for while health care is free.

17 It is interesting to note that there is a considerable element of compulsion involved, as the transfer of some funds is linked to the successful completion of local agreements between local and health authorities (Lewis and Glennerster, 1996: 168). For an overview of earlier initiatives to promote collaboration cf. Ham (1992: 87ff).

18 For other examples of boundary issues between social and health care see Henwood *et al.* (1996: 45ff).

into the community by providing acute services in the patients' home, out-patient surgery and post-operative care (cf. Baggot, 1998: 223f; Ross and Mackenzie, 1996: 21). These developments reflect both extra capacities of hospitals as a result of bed closures and attempts to prevent admissions or facilitate early discharge. Moreover, with the promotion of a "primary care-led NHS" (NHS Executive, 1996; Hibbs, 1996) GPs are assuming an increasingly central role in community health care, both as purchasers and providers[19]. The underlying assumption is that GPs are closer to the patient and are, therefore, better placed to identify needs. Since 1993, for example, GP fundholders can also purchase community nursing services. Further, following earlier changes to the GP contract the number of practice nurses employed by GPs has risen considerably. This is significant, as their work partly overlaps with those of nurses practising in the community (Atkin and Lunt, 1996: 86).

The German debate also characterises the development of care outside hospitals as a "history of neglect". However, whereas the British literature tends to refer to the general nature of community care, its German counterpart focuses on country-specific peculiarities, arguing that Germany lags behind the development in other West European countries (cf. Alber, 1990: 347ff; Alber, 1995: 136ff; Bräutigam and Schmid, 1996)[20]. It is argued that the insurance orientation of the German welfare system hinders the development of care for groups such as the elderly or physically disabled, as it is intrinsically biased towards the working population. At an institutional level this is reflected in insecure funding and in corporatist governance arrangements, dominated by employers and employees. Care outside hospitals, then,

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19 The importance of primary care-based services is also stressed by the Labour government's White Paper "The New NHS. Modern. Dependable" (Department of Health, 1997). It provided the basis for the creation of primary care groups in April 1999, which provide, plan and commission care for a group of patients in a given area. Interestingly, besides GPs these also include community nurses.

20 From a comparative perspective Tester (1996: 18) characterises rudimentary provision of care facilities for the elderly in Germany as typical for a "conservative-corporatist welfare state regime".

was long considered as part of "social welfare" rather than "social policy"[21]. Following the principle of subsidiarity and self-help, it was covered by the social assistance scheme, rather than by the health insurance which is restricted to acute treatable illnesses (cf. Dieck, 1994: 253f; Korporal, 1986: 228ff; Stüwe, 1993: 117)[22]. Moreover, with the insurance model the interests of employers and employees prevail and under circumstances of financial constraints this encourages a pre-occupation with cost containment. The interests of users are not represented, either directly or indirectly, for example by the state.

The amorphous nature of care outside hospitals is also reflected in the provision of services, which is based on the principle of subsidiarity and it is dominated by non-public, that is independent non-profit (*freigemeinnützige*) providers (cf. Stüwe, 1993: 120)[23]. More specifically, domiciliary care services "... were, until about 1970, mainly the domain of charitable organisations and parishes and were largely provided free of charge to those defined as needy" (Dieck, 1994: 258)[24]. In the 1970s and with the falling numbers of women in religious orders, many of these were transformed into community care centres (*Sozialstationen)*, run by the established non-profit organisations and in principle offering domiciliary health care (*häusliche Krankenpflege*), care for the elderly (*Altenpflege*) and care for families

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21 But, as outlined below, some aspects of care in domiciliary settings were (and are) covered by the health insurance, notably care which either supports medical treatment or which substitutes hospital treatment. This led to the paradoxical situation that while the health insurance played a major role in the financing of acute domiciliary care, long-term care needs remained largely unmet, as they were only covered by social assistance (cf. Institut für empirische Soziologie Nürnberg, 1992: 75ff).

22 The restrictive nature of social assistance arises from that fact that it is means-tested: it is subsidiary to other sources of support, either by the different branches of the insurance system or by relatives. Moreover, the budgets of local authorities, which finance social assistance, "... have recently come under heavy strain due to the problems of long-term unemployment and immigration ...", and this has led to high pressures for cost containment (Alber, 1995: 137). For an overview of the legal provisions themselves cf. Kettler (1992: 108ff).

23 In North Rhine-Westfalia, for example, in 1993 65.43% of community care centres were run by independent, non-profit providers (own calculation, based on Landesamt für Datenverarbeitung und Statistik, 1995).

24 For an overview of the historical development of care in domiciliary settings see Moers (1997) and for care facilities for the elderly see Kettler (1992: 67ff).

(*Familienpflege*) (cf. Herold, 1990: 340; Höfert, 1985: 337f; Korporal, 1986: 231f)[25]. Initially, community care centres were envisaged to provide a wide range of health *and* social care services, as well as to stimulate informal care by building networks of neighbourhood support or offering training courses for informal carers. But in practice, community care centres primarily provide health-oriented care, relieving the pressure on long-term care facilities in hospitals (Moers, 1997: 106f)[26]. The establishment of community care centres was significant as it marked the beginning of a stronger public interest in non-residential care (Stüwe, 1993: 114).

However, the insecure funding and the lack of incentives to develop further the provision of care outside hospitals were increasingly seen as problematic[27]: local authorities were concerned about the cost of social assistance and the prolonged stay of elderly patients in hospitals (due to lack of alternatives) was regarded as an important factor contributing to the rise of hospital expenditure (cf. Dieck, 1994: 264; Korporal, 1986: 227)[28]. These concerns were exacerbated by the projected increase in demand as a result of demographic and epidemiological changes. The 1989 Health Care Reform Act made a first step towards addressing these problems. It extended the scope of the health insurance to include some aspects of care outside hospitals, notably respite care and support for highly dependent patients (cf. Alber, 1990: 350; Dieck, 1994: 259f; Stüwe, 1993: 116)[29]. More importantly, in 1994 the social insurance was extended and the new long-term care insurance

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25 For an overview of the development of community care centre specifically in North Rhine-Westfalia cf. Holz (1990).

26 Community care centres are by far the most widespread form of service provision. In 1993 49.10% of all providers were community care centres, followed by parish-based care centres (*Gemeindekrankenpflegestationen*) (17.15%), domestic services (*Mobile Soziale Dienste*) (16.8%), domestic and family care centres (*Haus- und Familienpflegestationen*) (9.97%) and village-based care centres (*Dorfhelferinnenstationen*) (6.98%); (own calculations, based on Bundesarbeitsgemeinschaft der Freien Wohlfahrtspflege, 1994). For a more detailed discussion of these different types of service provision cf. Institut für empirische Soziologie Nürnberg (1992).

27 For an overview of the debate see Meyer (1996: chapter 1).

28 For a critical analysis of this view see Priester (1989).

29 For an evaluation of these changes cf. Engels (1992).

(*Pflegeversicherung*) was introduced, covering residential and domiciliary services[30]. Although this has raised the profile of long-term care, the scope of the new insurance remains limited, as it only provides basic coverage intended to complement informal care (cf. Baum, 1995: 19; Böhme, 1995: 33f). In addition, the 'market' for care outside hospitals has been opened up and the established non-profit providers ceased to be granted preference over new, smaller and private providers. Similarly, hospitals are now under considerable pressure to reduce their number of beds, for example, by altering their usage (Faber, 1994: 27; Medizinisch-Technischer-Dialog, 1995). Thus, bed capacity no longer needed for acute care may be re-allocated to long-term care.

Another factor contributing to the structural complexity of care outside hospitals is the institutionally reinforced distinction between different types of care. Traditionally, a distinction was made between care interventions which *improved* the patient's health, and those which simply *maintained* it; that is between illness and the need for medical treatment (*Krankheit/Behandlungsbedürftigkeit*) and the need for care (*Pflegebedürftigkeit*) (cf. Eberle, 1993: 202ff). On this basis the eligibility for health insurance coverage and income support respectively was determined. Thus, with its focus on chronic illness, long-term care tended to be excluded from health insurance coverage. However, there were (and still are) two cases in which the health insurance pays for domiciliary care: either to avoid or shorten hospital stays, or to support the treatment undertaken by office-based doctors. While the first type of care is limited to four weeks, there is no time limit on the second. Following the introduction of the long-term care insurance, this was superseded by a similar distinction, notably between medically-related and basic care (*Grund-* and *Behandlungspflege*). While these two types of care fall into the remit of the health and long-term care insurance respectively, the boundary between them is blurred: by emphasising the primacy of prevention and rehabilitation, the long-term care

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30 For an overview cf. Böhme (1995), Deutscher Verein für öffentliche und private Fürsorge (1995), Evers (1995), Gaschler (1995), Igl (1995), Kesselheim and Tophoven (1994), Meyer (1996), Schunk (1998).

insurance defines the need for care in dynamic terms and as a state which can be *treated* (Igl, 1995: 7, similarly Krahmer, 1995). It has some resemblance, then, to the focus of the health insurance, which covers all those (medical) interventions which *improve* the health of patients.

In summary, in both countries community care has tended to be ill-defined, reflecting complex institutional structures of a marginal area of the welfare state. Concerns about the inadequacy and later about the costs of institutionally-based care have both raised the profile of community care and challenged the status quo. In policy terms, the challenge was to respond to potentially increasing demand in ways which would not be too costly. In both countries, recent changes point to a more explicit emphasis on informal care, as reflected in the notions of "care by the community" in the case of Britain and the "new subsidiarity" of the long-term care insurance. Although the higher profile of community care has shifted its emphasis, its meaning remains amorphous, as does the institutional context in which it is provided.

Nursing staff working in the community

Defining community care is difficult: compared to hospitals it is not only much more complex in spatial terms, but also characterised by overlapping institutional responsibilities and provision structures. This makes for a wide range of occupations involved in the provision of community care. Here, nursing staff tend to be concerned with health as opposed to social aspects of care. With regard to the case study below particular attention is paid to nursing staff providing care in non-residential settings. The types of care provided, however, differ: in Britain it ranges from home-based care by district nurses to health promotion by health visitors and school nurses. Their German colleagues, by contrast, primarily provide care in domiciliary settings. In part this reflects the lack of community care-oriented qualifications in nursing and also explains the importance of social care-oriented occupations. In addition, compared to Britain, non-qualified staff play a more significant role.

In Britain, the Cumberlege Report identified district nurses, health visitors and school nurses as the core of "neighbourhood nursing"[31]. In contrast, community midwives, community psychiatric nurses and mental handicap nurses were regarded as peripheral[32]. The largest group within this 'core' are district nurses, who provide clinical care in the patient's home. With demographic/epidemiological changes and the shift from secondary to primary care they increasingly focus on elderly and/or highly dependent patients. In contrast, health visitors are largely concerned with children under five and their families, adopting a preventive (as opposed to clinical) approach. Finally, school nurses deal with both screening programmes as well as health advice and promotion. While they are responsible for individual schools, they are employed by community trusts. More recently, there has also been an increasing number of practice nurses, who play a major role in health promotion, such as health clinics, immunisation and family planning (cf. Ross and Mackenzie, 1996: 17; Greenfield, 1992: 74). The last group is directly employed by GPs, whereas district nurses and health visitors may (or may not) be affiliated to GP practices, but are ultimately employed by community trusts.

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31 For an overview of current trends in this 'core group' cf. McDonald *et al.* (1997).

32 For an overview of the Cumberlege Report cf. Ottewill and Wall (1990).

Table 12.1 Nursing manpower distribution in Scotland in 1995 in wholetime equivalents and percent

	wholetime equivalents	in percent	in percent
all qualified nursing staff	35 084.2	100	
qualified hospital staff	29 647.9	84.5	
other qualified nursing staff	5 436.3	15.5	100
health visitors	1 443.1		26.54
district nurses	1 705.8		31.38
community midwives	309.4		5.69
community psychiatric nurses	372.6		6.85
community mental handicap nurses	166.2		3.06
clinic/school nurses	487.6		8.97
combined duty nurse	507.6		9.34
others	444.0		8.17

taken from: Information and Statistics Division (1996), percentages are based on own calculations

The data above indicate that nurses working in the community ("other qualified nursing staff") account for about 15% of the entire (qualified) nursing workforce. Interestingly, this figure has not changed significantly in recent years[33], despite the

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[33] In Scotland, in 1980 17.2% of qualified nursing staff worked in the community, compared to 15.14% in 1990 (own calculations, based on Information and Statistics Division, 1996). Interestingly, there have not necessarily be any hidden changes at the level of workloads. While the number of home visits and persons seen at home, for example, has fallen in health

policy emphasis on care in non-hospital settings. This is also reflected in the share of NHS gross expenditure (of the UK) spent on community health services. While it has risen from 6.1% in 1980 to 8.6% in 1995, the spending on community care remains under 10% (Office of Health Economics, 1995). Among the nursing staff working in the community, district nurses and health visitors represent by far the largest groups, followed by clinic/school nurses.

Community nursing has traditionally been characterised by a relatively high percentage of specialist nurses, that is health visitors and district nurses. However, this is challenged by the emphasis of recent policy initiatives on reviewing the *composition* of community nursing rather than merely staffing levels, as done by more traditional approaches to personnel management[34]. The so-called "skill-mix", however, is ambiguous as it can be a basis for both the development of occupational roles as well as the substitution of staff with different levels of training[35]. In this respect it is significant that the debate tends to focus on grades rather than skills and their most *effective* mix. A report by the Value for Money Unit on skill-mix in district nursing (NHS Executive, Value for Money Unit, 1992), for example, calls for a clearer separation between the management and the delivery of health care. Considering the relatively high numbers of specialist staff in district nursing, this in effect implies increasing the number of less or non-qualified staff at the expense of specialist staff[36]. Compared to other personnel-related measures such as wage freezes or cuts, the change of grade mixes also offers a fairly subtle and less controversial

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visiting, they have risen only marginally in district nursing (Information and Statistics Division, 1996 and own calculations).

34 The 1986 policy document "Mix and match: a review of nursing skill-mix" played an important role in initiating the debate, while the Resource Management Initiative helped to provide the information needed. For an overview of the debate cf. Buchan and Seccombe (1993: 184f), Car-Hill *et al.* (1992), Gibbs *et al.* (1991), Lightfoot *et al.* (1992), Ross and Mackenzie (1996: 141ff), Thornley (1996).

35 For a critical discussion cf. Ball *et al.* (1989), Community and District Nursing Association (1995), UNISON (without year, a).

36 For examples of reviews of 'skill-mixes' cf. McIntosh *et al.* (1994), North and Mid Hampshire Health Commission (1995).

means of containing health care expenditure. This may explain why the changes in the area of staffing levels and mix have been more significant than in any other area of personnel management (Buchan and Seccombe, 1993: 185). In this respect the changes in nursing education, particularly the introduction of health care assistants and more generic first-level training, are likely to provide a catalyst for change, and Lightfoot *et al.* (1992: 13) suggest that community nursing may become more generic in the future. In his study of the changes in skill-mix and pay determination in two trusts Grimshaw (1999: 321) concludes that "... the new scope for managerial prerogative associated with recruiting staff (that is health care assistants) on local pay appears to provide an important lever in the restructuring of the skills-profile of the entire nursing workforce".

The discussion about "skill-mix" is particularly significant in the context of community care, as the percentage of qualified nursing staff is considerably higher than in hospitals (91.62% compared to 63.83%)[37]. This is also reflected by the high percentage of nurses with a specialist qualification: while only 14.74% of all qualified nurses in hospitals were G-grade or above, 61.88% and 92.98% of all qualified district nursing and health visiting staff respectively were G grade or above[38]. Compared to hospitals most of the nursing staff working in the community are specialists. Between 1990 and 1995, for example, the percentage of health visitors with a G-grade or above fell by 7.02 points, and by 8.41 points in the case of district nursing, reflecting pressures to review the mix of different grades[39]. Although these developments are significant they are not as dramatic as one might expect[40].

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37 These percentages are based on wholetime equivalents in Scotland in 1995 (own calculations, based on Information and Statistics Division, 1996).

38 These percentages are based on wholetime equivalents in Scotland in 1995 (own calculations, based on Information and Statistics Division, 1996).

39 These percentages are based on wholetime equivalents in Scotland in 1995 (own calculations, based on Information and Statistics Division, 1996).

40 Against this background it could be argued that community nursing has remained relatively unaffected by change. This might reflect low turnover-rates, combined with the reluctance of management to take radical steps, such as making specialist staff redundant and replacing them

While in Britain, health care outside hospitals is provided by nursing staff with a community-oriented qualification, the majority of their colleagues in Germany have a general nursing qualification. This reflects the lack of specific training schemes. Traditionally, community nursing care was delivered by so-called *Gemeindeschwestern*, who were affiliated to local parishes and who often belonged to religious orders (Herold, 1990). It was only in the 1970s when the number of recruits fell, that community nursing care became more secular and a more formal approach to education was required. However, few nurses have a second-level qualification in community nursing (*Gemeindekrankenpflege*), as it is neither a formal requirement for practising in the community, nor rewarded in financial terms. In part, this is compensated by a broader range of social care-oriented qualifications. Closest to nursing is the first-level qualification in geriatric care (*Altenpflege*), but this tends to focus on residential as opposed to domiciliary care settings (Frerichs, 1995: 120f)[41]. In contrast, the training of home and family helps (*Haus-* and *Familienpfleger/in*) as well as village helps (*Dorfhelfer/in*) has a stronger domestic (*hauswirtschaftliche*) orientation (Bauer-Söllner, 1992: 132ff; Forschungsgesellschaft für Gerontologie, 1996: 21ff). The education of these groups is formally recognised and regulated by legislation in some states, whereas the training of ancillary home and family helps largely lies in the hands of individual providers (Bauer-Söllner, 1992: 134f)[42]. At the same time, formal training for volunteers has become more important. This is enhanced by the fact that a considerable number of volunteers have a formal nursing qualification (Dietrich, 1993: 79).

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with lower-qualified staff. Alternatively, this might point to the limits of skill-mix in community care, where nursing staff have to work on their own.

41 For an overview of first-level education in geriatric care cf. Forschungsgesellschaft für Gerontologie (1996), Krutzsch-Selle (1994) and for an overview of the historical development and present features of geriatric care cf. Cappell (1996).

42 Here, it also has to be taken into account that the notion of a basic/auxiliary qualification is unusual in the context of German training schemes (Forschungsgesellschaft für Gerontologie, 1996: 16).

In some respects, the differentiation among these differently qualified staff follows different types of care, that is medically-related care (*Behandlungspflege*), basic care (*Grundpflege*), domestic help (*hauswirtschaftliche Hilfen*) and personal support, that is counselling (*Hilfe zur Lebensbewältigung*)[43]. The responsibilities of qualified general and geriatric nurses, then, are very similar and concentrate on the first two types of care[44]. In contrast, home and family-helps tend to provide domestic tasks as well as support in the areas of medically-related, basic and child care (cf. Bauer-Söllner, 1992: 132f; Forschungsgesellschaft für Gerontologie, 1996: 14). In practice, these boundaries are far less clearly defined. This also reflects the nature of home-based care where nursing staff tend to work on their own.

The introduction of the long-term care insurance has again highlighted issues about the relationship between qualified and non-qualified staff (cf. Klie, 1997a, b), as the legal requirements in terms of qualification only define basic standards: care has to be provided under the supervision of a qualified member of staff, but the care giver her/himself does not necessarily have to be qualified. The requirements for medically-related care are stricter, but more and more care is defined as basic care. Considering that the majority of domiciliary care was *de facto* financed by the health insurance, the recent changes clearly challenge the composition of existing nursing teams.

In Germany, the official statistics at state and federal level provide little information on nursing staff working in non-hospital settings and almost no information on the ratios between different specialities or levels of training[45]. The same applies to the

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43 This distinction is taken from Stüwe (1993: 119). In community care centres, which deliver the majority of domiciliary care services, the first two types of care prevail (Bauer-Söllner, 1992: 117f).

44 For an overview of the different areas covered by geriatric nursing cf. Bauer-Söllner (1992: 141).

45 This will change in the next couple of years as the long-term care legislation requires the collection of more detailed data. The first set of data is expected to be published at the end of 2000 at the earliest.

data collected by the umbrella organisation of independent, non-profit providers (*Bundesverband der Freien Wohlfahrtspflege*)[46]. The most up-to-date and comprehensive statistics currently available date from the beginning of 1997 and were collected as part of a study by the research institute of the local insurance funds (Wissenschaftliches Institut der Ortskrankenkassen).

The limited official statistics available suggest that only a small percentage of qualified nurses work in non-hospital settings (4.56% in North Rhine-Westfalia in 1994)[47] and that staff with a (general) nursing qualification account for 53.33% of the staff providing care in non-residential settings[48]. The statistics published by the research institute of the local insurance funds give a more detailed overview. As there are no specific data available for North Rhine-Westfalia, in the following, the cumulative figures for all states are used.

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46 For a more detailed discussion on the available data cf. Forschungsgesellschaft für Gerontologie (1996: 82ff), Kühnert and Schnabel (1996: 413).

47 Based on 1994 figures for North Rhine-Westfalia. Own calculations, based on Landesamt für Datenverarbeitung und Statistik (1996).

48 Based on 1994 figures for North Rhine-Westfalia. Own calculations, based on Landesamt für Datenverarbeitung und Statistik (1996).

Table 12.2 Qualification of personnel in domiciliary care in percent

general nurse (*Krankenschwester*)	32.4
paediatric nurse (*Kinderkrankenschwester*)	2.5
staff with first-level qualification in geriatric care (*Altenpfleger/in*)	8.0
staff with special needs qualification (*Heilerziehunsgpfleger/in*)	0.1
other caring occupation[49]	28.4
nursing students	2.6
men doing community service	3.7
without qualification	7.7
catering, cleaning and clerical staff	11.7
therapeutic occupations	2.1
other occupations	0.8

taken from: Wissenschaftliches Institut der Ortskrankenkassen (1998)

The figures suggest that in domiciliary care a clear majority of qualified staff has a general nursing qualification. At first sight, about 70% of nursing staff have a formal

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[49] This includes home, family and village helps, auxiliary home and family helps, and enrolled nurses. Although these type of staff have a qualification, they are formally not treated as "qualified" (*examiniert*).

qualification (rows 1-5 taken together). However, this is deceptive as the staff with social care-oriented and auxiliary qualifications ("other care occupations") are not considered as "qualified" (*examiniert*). This reduces the share of qualified staff to 43%. The level of qualification is also related to the type of contract: compared to "other care occupations", for example, staff with a general nursing qualification is more likely to work full-time (Wissenschaftliches Institut der Ortskrankenkassen, 1998: 34). Similarly, full-time staff account for less than half of the workforce (44%), followed by part-time and casual staff (34% and 22% respectively) (Wissenschaftliches Institut der Ortskrankenkassen, 1998: 32). Adopting a longitudinal perspective, a secondary analysis of other data sets suggests that although the total number of staff in domiciliary care has increased, this is largely due to an increase of part-time staff (Forschungsgesellschaft für Gerontologie, 1996: 98ff)[50]. Similarly, Dietrich (1993) points to the increase of non-qualified staff. Here, Becker and Meifort (1994: 19) suggest that this may reflect the expansion of home-based services and domestic tasks.

Comparing and contrasting the observations on nursing staff working in community care, the most striking feature is the considerably higher percentage of qualified nursing staff in the British case. It could be argued that this reflects the existence of specialist qualification in community *nursing*. In Germany, by contrast, almost a third of staff have social care-oriented qualifications. If these were treated as "qualified nurses" the percentage of qualified staff would be almost as high as in Britain. The difference in the level of qualification, then, reflects different ways in which the territory of community care is divided among various occupational groups. Compared to their German counterparts, nurses in Britain have secured a more influential position. Alternatively, it could be argued that these differences reflect broader institutional characteristics of health governance, that is: the degree to which

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[50] In 1993, among the community care centres run by non-profit providers the ratio between full- and part-time staff was roughly 5:4 (20 599 compared to 15 644) (Bundesarbeitsgemeinschaft der Freien Wohlfahrtspflege, 1994).

community care is marginal differs. In Britain, community care has been part of the NHS since its creation, whereas in Germany it was only integrated into the mainstream social insurance system in the mid 1990s. Further, the central government in Britain potentially also has greater powers to intervene, while the role of its German counterpart is more limited. This echoes Tester's (1996: 18) argument that a rudimentary provision of community care (in her case for the elderly) is typical for conservative-corporatist welfare states.

The analysis of two localities

Chapters 13-15 focus on different dimensions of the occupational governance of internal boundaries in community nursing and provide a detailed comparative analysis of the data gathered from the two localities in Britain and Germany. The study focuses on community nursing care for the elderly, provided in the elderly people's homes. While in Britain this type of care is primarily delivered by district nursing staff, in Germany a whole range of different community nursing staff is involved. The use of terminology, therefore, differs depending on which country is referred to. Where nursing in both countries is concerned, the more generic term "community nurses" is used. The organisation of these community nursing services at local level varies: in the German locality community nursing services are provided by three teams (*Sozialstationen*), which are accountable to the senior manager (*Gesamtleiter*) who has the overall responsibility. The community nursing services are part of a larger organisation of the local non-profit provider. Similarly, the district nursing services in the British locality are part of a community trust which also provides other community nursing services, mental health services, services for older people and people with learning disabilities. It consists of two localities, each of which is headed by a locality director. The community nursing services are led by a nursing manager who also has budgetary responsibilities.

The following figures provide a schematic overview of the organisation of community nursing services, both at local level and beyond. They are also an important point of reference for the analysis in the subsequent chapters.

Figure 12.2 Organisation of district nursing services in the British case

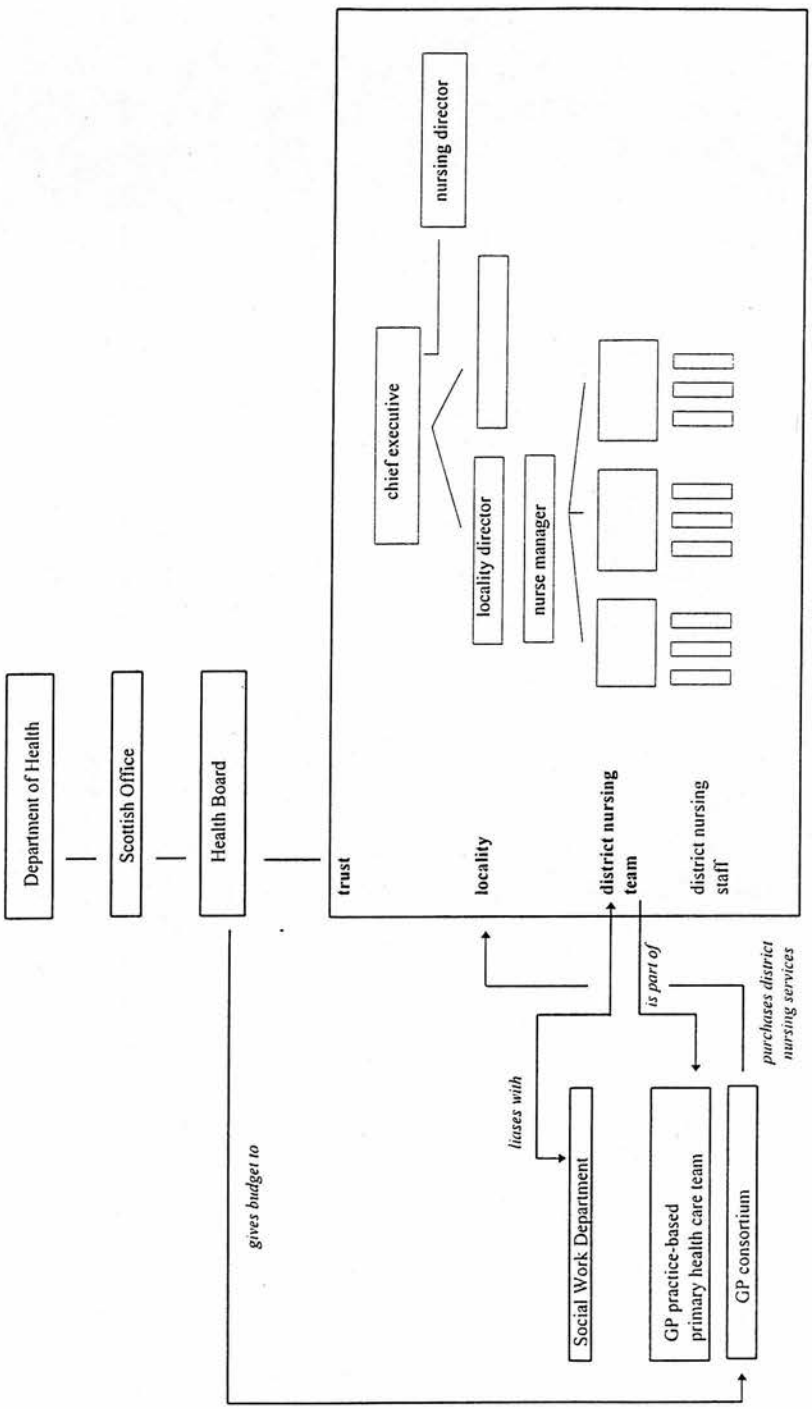
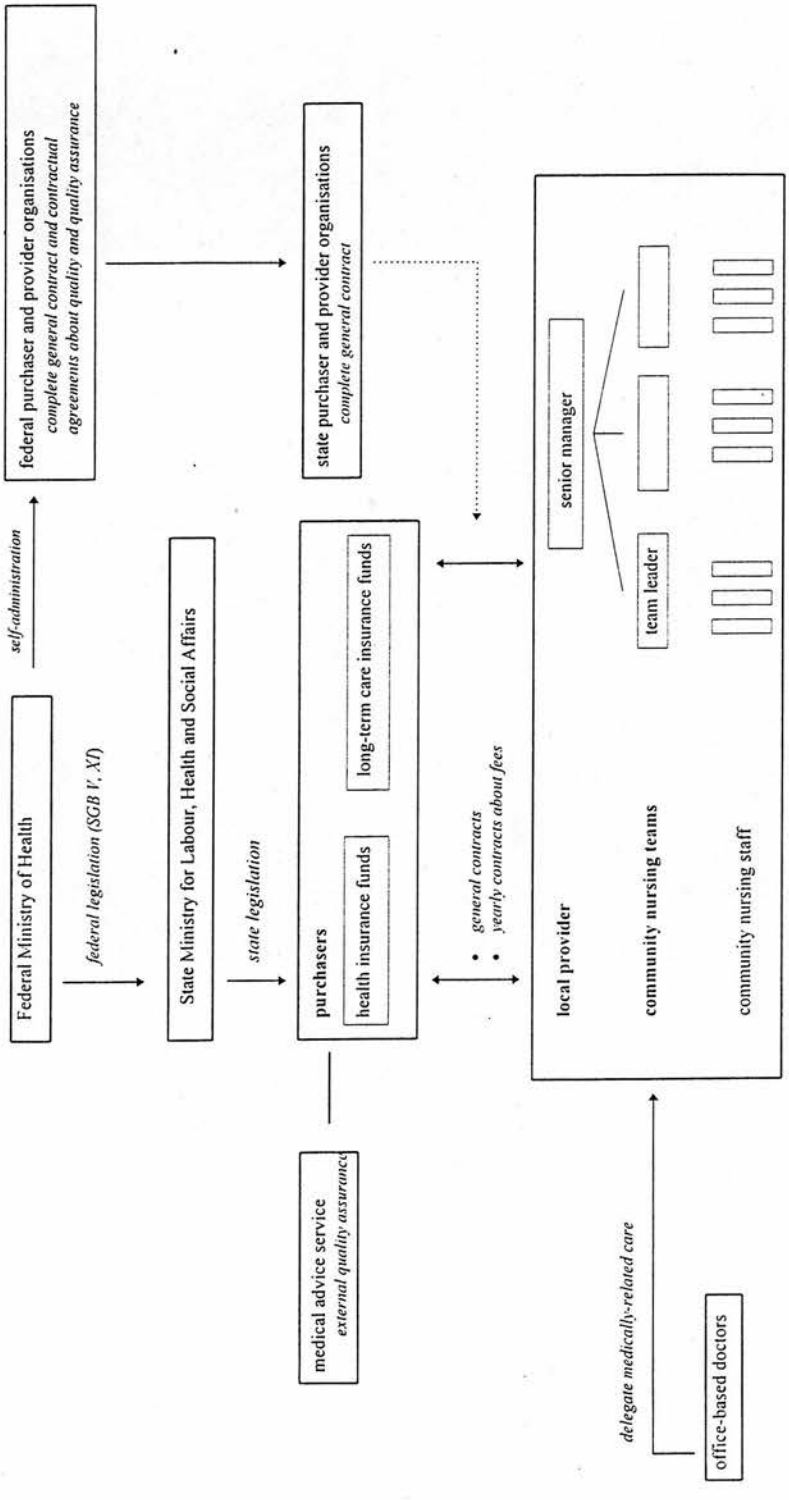


Figure 12.3 **Organisation of community nursing services in the German case**



The aim of the case study is to analyse the occupational governance of internal boundaries in community nursing from a *micro*-perspective in order to understand more fully the occupational governance of nursing. It provides a detailed analysis of the interview material collected in the two localities. Within this framework chapters 13-15 analyse different dimensions of the occupational governance of internal boundaries in community nursing, representing different areas of decision-making. Here, particular attention is paid to the actors involved, the institutional context in which they operate and the current dynamics with which community nursing services are confronted. As indicated in the discussion of the data analysis[51], the dimensions of the governance of internal boundaries evolved partly from the operationalisation of theoretical concepts and partly from the analysis itself. Internal boundaries can be understood as the interface between nursing staff with different levels of training. Here, the notion of governance concerns all those processes, mechanisms and institutions by which this interface is determined. In terms of operationalisation, it could be argued that governance has a dynamic and a static element: it encompasses the division of labour between nursing staff and the composition of community nursing teams, also referred to as grade-mix[52]. The concept of governance is further operationalised by looking at situations where internal boundaries are likely to be subject to decision-making. These are the processes of filling a vacancy and allocating workloads respectively. Further, the analysis of the data suggested including broader issues of the governance of community nurses' practice. In summary, the following dimensions of the occupational governance of internal boundaries in community nursing are analysed:

(1) community nurses' practice,

(2) grade-mix,

(3) the division of labour.

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51 See chapter 6.

52 This corresponds to the distinction between short and medium/long-term aspects of internal boundaries made at the beginning of this chapter.

The micro-analysis of the governance of internal boundaries begins by looking at decisions about community nurses' practice (chapter 13). It is emphasised that negotiations about contracts assume a central role. These are standardised and centralised in Germany as they complement legal provisions and more localised in Britain. In both counties, contractual negotiations are complemented by case-by-case decisions, particularly as part of the process of referral/delegation by office-based doctors. Subsequently, the governance of grade-mix is examined (chapter 14). It is argued that decisions are predominantly taken at local level, notably in the context of filling a vacancy. While the final decision rests with the local provider, it is subject to the powerful influence of GPs as purchasers and to financial pressures (and the basic legal requirements) in the German case. In comparison, the views of community nursing teams play a subordinate role. Finally, the governance of the division of labour is analysed (chapter 15). Again, decisions are taken at local level, as part of the allocation of workloads. Here, community nursing teams play a key role, although the criteria they use vary. The concluding discussion draws together the analysis, focusing on the modes and levels of governance and the actors involved (chapter 16). It also considers the macro-analysis of the occupational governance of nursing.

13 Community nurses' practice

This chapter analyses the occupational governance of community nurses' practice from the perspective of the two localities in Britain and Germany. It discusses how community nursing services are organised and what role different actors have in the governance of nurses' practice. It provides the context for the more detailed analysis of the occupational governance of grade-mix and the division of labour in chapters 14 and 15. The analysis begins by examining the organisation of community nurses' practice at the level of the teams, identifying the relative importance of "collective" and "single-handed" styles of leadership. It is argued that these partly reflect the size and the level of qualification of the teams. Subsequently, the role of key actors in the governance of community nurses' practice is examined. Although community nurses' practice is only of interest as the *object* of governance, it is useful to distinguish between decisions about the scope of practice, and those which concern the ways in which services are delivered. In both countries, contractual negotiations between purchasers and providers play an important role, but these are complemented by case-by-case decisions by office-based doctors as part of the process of referral/delegation. In the British case, the GP consortium and the trust as local actors have a direct role in the governance of community nurses' practice. The influence of insurance funds and provider organisations in Germany, by contrast, is not only limited to certain types of care, but also filtered through multiple layers of legal provisions and contractual agreements. Further, whereas in both countries the influence of doctors can be captured in the notion of medical dominance, it manifests itself in different ways. It ranges from the relative importance of organisational dependence in the British locality to dominance which mainly rests on professional hierarchies in the German case. The conclusions provide a systematic summary of the analysis.

Teams - the organisation of community nurses' practice

At a general level, the practice of community nurses is similar in both countries: in contrast to hospital settings, community nurses work in patients' homes, and tend to work on their own. But this raises the question of how the isolated activities of community nurses are co-ordinated and how community nursing teams are organised. Particular attention is paid to the distribution of managerial responsibilities. Despite common basic features, the internal structure of community nursing teams in the British and German localities reflects different emphases in the style of leadership. It gravitates towards either end of a continuum between "collectivist" and "single-handed" leadership. In part, this also appears to be related to the size of community nursing teams and the level of qualification. However, these two approaches to organising teams do not necessarily exclude each other. In the British case, for example, collective leadership and a strong sense of working in a team co-exist with hierarchical elements.

In the case of the German locality, the community nursing teams comprise more than ten members of staff, less than half of whom are qualified[1]. Staff were primarily distinguished according to whether they are working full or part-time. However, this distinction strongly correlates with different levels of qualification, in that most part-time staff do not have a nursing qualification or formal training. The distinction between these two groups is enhanced by the fact that they often work different shifts: during the day care tends to be provided by full-time (and qualified) staff, whereas evenings and weekends tend to be covered by part-time (non-qualified) staff. The allocation of caseloads follows a regular pattern as each full-time community

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[1] In the German context "qualified" (*examiniert*) means that staff have a qualification in nursing, which they receive after three years of formal training.

In terms of the organisation of the team's workload, the numbers of staff appear to be particularly significant. One of the community nursing teams comprises 5 qualified nurses (excluding the team leader), one geriatric nursing student, and part-time staff most of whom are non-qualified. Similarly, the other community nursing team consists of 5 qualified staff, one enrolled nurse (*Krankenpflegehelferin*) and 10 part-time staff, 3 of whom are qualified.

nurse covers a certain geographical area, and even part-time staff tend to look after the same group of patients.

The team leader (*Einsatzleitung*) plays a central role in the allocation of work, since she draws up the rota. Her position is further strengthened by the fact that each member of staff reports back to the team leader on a daily basis (*Übergabe*). Interestingly, the leader of one of the teams argued that such a centralised system of handling information and taking decisions is necessary due to the isolated nature of community nurses' practice. She also perceived her role as going well beyond being a "common point of contact".

> "It is simply the case that it is I who primarily have to work together with the others (other nursing staff). Because nurses working in domiciliary care tend to be loners."[2]

This view is particularly significant considering that this team leader hardly does any hands-on-care apart from the occasional cover for sick leave[3]. Her position is typically managerial in its nature: she makes decisions on activities with which she is not directly involved, but at the same time depends on correct and up-to-date information on what is happening at the 'frontline'. Here, besides the daily feedback by individual members of staff, the weekly team meetings (*Dienstbesprechungen*) are of central importance[4].

The ambivalent position of the team leader was reflected in decisions about the allocation of case loads. In principle, this is the responsibility of the team leader as is the assessment of whether a non-qualified member of staff is capable of looking after a particular patient. But in one of the community nursing teams it was pointed out

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2 "Das ist halt so, daß ich überwiegend mit den Leuten zusammenarbeiten muß. Weil als Krankenschwester im ambulanten Bereich, ist man eben Einzelkämpfer."

3 In contrast, the team leader of the other team is more regularly involved, and delivers 2 hours hands-on-care per day.

4 In addition, the care documentation which is kept in patients' homes is central for the communication between different members of staff.

that, in effect, the responsibility is shared between the team leader and the qualified members of staff[5].

> "It (the decision as to who looks after a certain patient) is primarily in the hands of the team leader or her deputy. But, when coming in in the morning, we as the other full-time (and qualified) staff are responsible for keeping an eye on how things were done the previous evening. ... All of us have to be alert, especially because this is difficult to do when working from a desk."[6]

At the same time though, there are tasks which are exclusive to the team leader. These are initial visits to patients and the completion of contracts (*Pflegeverträge*) as well as visits to patients who receive cash benefits from the long-term care insurance[7]. In contrast, the role of the team in decisions about filling a vacancy is less clear-cut: one team leader expressed the view that the team is hardly involved in the appointment procedure. In contrast, the community nursing teams felt that they have an input into the process, although it is limited: whereas the appointment of part-time staff is in the hands of the team leader, this is different in the case of full-time staff[8].

In summary, the internal structure of the community nursing teams in the German locality appears to be relatively hierarchical in its nature, in that managerial responsibilities are concentrated in the hands of the team leader. But at the same time, the style of leadership also has collective elements, in that most of the managerial responsibilities are to some degree informally shared with the team, and

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5 The same applies to the case of sick leave and other instances of temporary absence.

6 "Das (die Entscheidung, welche Kraft bei welchem Patienten eingesetzt wird) ist primär die Entscheidung der Einsatzleitung oder ihrer Vertretung, wer da jetzt eingesetzt wird. Aber wir anderen Hauptamtlichen (und Examinierten) haben eben die Aufgabe, wenn wir dann am anderen Tag wieder hinkommen, ein Auge 'drauf zu haben, wie ist das gelaufen im Abenddienst vorher. ... Da sind dann wieder alle gefragt, da wieder mit aufmerksam zu sein. Weil vom Schreibtisch aus, ist das auch nicht immer zu machen."

7 The long-term care legislation (§ 37, paragraph 3, SGB XI) requires patients who receive cash benefits to be seen every three to six months by a local provider of their choice. The provider has to assess whether the care patients receive is adequate, and has to report back to the respective insurance fund.

8 For a more detailed discussion of the process of filling a vacancy see the analysis of the governance of grade-mix in chapter 14.

the full-time staff in particular. Nevertheless, there appears to be a clear sense of hierarchy, which was also reflected in the language used in the focus groups: community nursing staff referred to the team leader by using the formal title, that is "*Einsatzleitung*", rather than her name as they did with other colleagues (fieldnotes).

Compared to their German counterparts the district nursing teams in the British locality are smaller and more highly qualified: they comprise less than 10 members of staff, the majority of whom are qualified[9]. Among the qualified staff most have a specialist qualification in district nursing, and are G or F-grades[10]. Neither of the two teams has a team leader. Instead, managerial responsibilities are shared out between the G-grade nurses. In one team, one of the full-time G-grades draws up the rota for all members of staff, whereas in the other the case load is simply shared between two members of the sub-teams (fieldnotes). Besides liaising with the locality management and the GPs, a core (and exclusive) responsibility of the G-grade district nurses is to do the initial visits of patients, and to assess their care needs.

This suggests that whereas the organisation of community nursing teams in the German locality gravitates towards a "single-handed" style of leadership, in the locality in Britain it is more "collective" in its nature. Further, the district nursing teams appear to have a stronger sense of "being a team". A member of one district nursing team, for example, concluded a discussion of the responsibilities of different grades by saying that everybody works together. The "team spirit" may be due to the smaller size of the teams as well as the fact that the leadership responsibilities are shared. The communication between the team and its 'management' is therefore less

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9 In the context of Britain "qualified" are all those staff who had formal training leading to a registered qualification, that is enrolled nurses, staff nurses, and district nurses.

One of the district nursing teams comprises 3 specialist district nurses, one staff nurse, one district enrolled nurse, and two auxiliaries. The other district nursing team consists of 5 specialist district nurses, one staff nurse and 3 auxiliaries.

10 In the two teams nurses with a specialist qualification in district nursing are either G-grades or F-grades. However, in the expert interviews and focus groups specialist district nurses were generally referred to as "G-grades".

formalised: the team meets informally over lunch and uses message books as another central means of communication. The informal nature of communication and decision-making is further enhanced by the fact that the team works in sub groups, and that the majority of the team members have the same level of qualification respectively. Thus, whereas in the case of the British locality, teamwork appears to come more 'naturally', in Germany it is 'engineered' by the team leader.

The approach to leadership in the British case, however, also has hierarchical elements. The collectivism is élitist in its nature as it is restricted to the G-grade nurses. Their dominant position was particularly apparent in one of the district nursing teams, where most staff have a specialist qualification in district nursing. Referring to the team's view on future grade-mix, for example, one member of staff explained that the staff nurse was asked for her views, but that the final decision was taken by the G-grades[11]. There was also a clear sense of the subordinate position of non-qualified nursing staff in both teams. A member of one team, for example, emphasised that the G-grades tell the auxiliaries what to do.

In summary, the organisation of community nursing teams in each locality tends towards different modes of leadership, which appear to be related to the size and the overall level of qualification of the team. But at the same time, the "single-handed" approach in the German case co-exists with collective elements. The team leader partly shares her managerial responsibilities with the qualified members of the team. Similarly, in the British locality, the predominantly collective style of leadership also has hierarchical elements, in that managerial responsibilities tend to be restricted to staff with specialist qualifications.

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[11] The divide between G-grades and qualified non-G-grades was slightly less obvious in the other district nursing team. A possible explanation is that the staff nurse and district enrolled nurse each work alongside one G-grade nurse in a sub team (fieldnotes), and, thus, are closer to the realm of the G-grades. Further, because of her considerable work experience, the district enrolled nurse is a highly established member of the team.

Purchasing at local and state level

In general, community nursing services are purchased by the health board and the insurance funds (*Kranken-/Pflegeversicherung*) respectively. In the case of the British locality, a GP consortium receives funding from the health board, and purchases (among others) district nursing services from the local trust[12]. Consequently, the purchaser and provider negotiate contracts at local level. In contrast in Germany, contracts are completed between the peak organisations of purchasers and providers at state level. In both countries then, contractual negotiations play an important role in the governance of community nurses' practice. However, it appears that the difference in the organisation of purchasers and the wider institutional context in which they operate has some impact on their role in the governance of community nurses' practice. The purchasing organisation in the British locality for example can exert more direct influence.

In Germany, the health insurance funds (*Krankenkassen*) and the long-term care insurance funds (*Pflegekassen*) are the purchasers of community nursing services[13]. The insurance funds are firmly embedded in a framework of federal legislation and (legally-binding) agreements with the providers' peak associations at federal and state level. This considerably limits their scope when completing contracts with individual providers. In comparison, in the case of the British locality the purchasing structure is less legalistic and more localised: a GP consortium was set up in 1993, and encompasses all practices in the locality. The consortium is headed by a core group of five GPs. It is responsible for purchasing, and for representing the views of the GPs in the locality. While the British locality was an extreme case of localism, it

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12 The locality of the case study was one of the pilot sites for the health board's locality purchasing project. It was set up to enable GPs to purchase community services for their area.

13 Although they operate within different legal frameworks (*Sozialgesetzbuch V* and *XI* respectively), and are formally separate bodies, in many respects they *de facto* work as one organisation. Similarly, the divide in the financing of domiciliary care is not reflected at the level of service provision, and most providers offer both types of care.

points to more recent developments in health governance in Britain. As discussed earlier, policy initiatives since the mid 1980s have combined increasing centralism, especially in terms of funding and performance control, with a more localised operation of services[14]. The difference in the organisation of the purchasing function is also reflected in the purchaser's influence role in the governance of community nurses' practice: due to its local basis the consortium's influence is direct in its nature, and the contract with the local trust defines community nursing services. In Germany, the purchasers' role is much more indirect, as their influence is filtered by multiple layers of legislation and agreements at federal and state level; therefore, the definition of community nursing services is much more standardised, combining legal and contractual elements.

In the case of the British locality, the influence of the GP consortium as the purchaser of district nursing services is two-fold: shortly after the setting-up of the "primary care purchasing initiative" the consortium and the trust agreed on "specifications" which define district nursing services and the tasks they include. These form the basis for the yearly contract on the provision of district nursing services. Although the services described in the contract have to be in line with the strategic guidelines of the health board, the purchaser and provider have considerable freedom.

> "With the consortium we have a budget to buy community services ... . The health board have a role in overseeing us, but they cannot impose, we have a responsibility to follow their strategic lines. ... They (the health board) can suggest things to us (the consortium) but we are working within a broad framework, and we do not have to follow them exactly. ... There is flexibility. We don't totally disagree, ever (emphasis). But we do not totally agree either."

The role of the GP consortium in the governance of district nurses' practice featured prominently in the focus groups and expert interviews. The increasing demands on primary care services challenge existing boundaries between GPs and district nurses.

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[14] These are also at the core of the Labour government's reform of general practice. For a more detailed discussion see the analysis of health governance in chapter 7.

Not surprisingly, the specifications have provided an opportunity to re-define district nursing services, and to expand them[15]. Several interviewees also pointed out that the specifications have helped to clarify the role of district nurses. This suggests that contractual arrangements provide a means of formalising the practice of district nurses.

Another interesting issue concerns the perceived power of the consortium. The district nursing teams portrayed GPs as very influential.

> "We (district nurses) are not employed by them (GPs), but they are given the money to pay the locality management for our services. So, although we are not actually employed by them, they actually have a big say in what we do and do not do."

> "... the GPs (are) having too much say. Because they say they are buying our services 'I want you to do this and I want you to do that, because after all, I am paying for it.'"

The nurse manager had a similar view, particularly in relation to decisions about filling a vacancy[16]. The perceptions of the district nursing teams and the nursing manager were echoed by one of the senior partners who explained that, whereas in the past district nursing services had been solely determined by the trust, the GPs are now in a more influential position. Further, he argued that the GPs' power in part also stems from their exit option in that the consortium can, in principle, purchase district nursing services from any provider[17]. In contrast, the member of the core group of the consortium was much more cautious in her assessment.

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15 Similarly Tinsley and Luck (1998: 481) report "It appears that GP fundholders have sought changes to traditional working patterns (of community nurses) and, especially, extensions of the range of activities and greater flexibility of working patterns".

16 For a more detailed discussion see the analysis of the governance of grade-mix in chapter 14.

17 Interestingly, the German purchasers do not have this exit option: following the principle of "*Kontrahierungszwang*" the insurance funds have to contract the services of a provider, provided that it meets the requirements set out in the federal legislation. But even in the case of the British locality, the exit option is hardly existent as the trust is in effect in a monopoly position.

> "If one believed (the) Labour Party's manifesto, currently our consortium should be more powerful. I do not believe that to be the case. I do not believe that to be either the perception of the health board or the trust. Initially, the trust would do nothing. ... We were told by the board (health board) we had the autonomy to make decisions. And when we said that to the trust they wouldn't do anything except with the counter-signature of the board. And we still have a little bit of this history ... . But last year, we got what we wanted ... and this year we intend to get what we think we need."

She also pointed to the fact that the specifications agreed four years ago have not yet been met throughout the locality. It also has to be taken into account that the trust remains the employer of district nurses. The director of the locality, for example, pointed out that if GPs request an expansion of district nursing services, it is still the trust that will take the final decision. Similarly, although the services are specified by contract, it is up to the trust how these services are delivered.

As in the British case, in Germany community nursing services are also subject to contractual arrangements between purchasers and providers, but are based on legal provisions at federal level[18]. The services financed by the long-term care insurance and the health insurance are outlined by the relevant federal legislation (*Sozialgesetzbuch XI* and *V* respectively): following §14 paragraph 4 (SGB XI) the long-term care insurance covers physical care, help with mobility and nutrition as well as domestic support. Further, §75 (SGB XI) states that a general contract (*Rahmenvertrag*) between the peak associations of purchasers and providers at state level will define in more detail the contents of the services financed by the long-term care insurance. Consequently, the general contract (Rahmenvertrag, without year) lists the tasks which fall under the categories initially identified by the legislation. This task-orientation is fortified by the fact that providers are reimbursed on a fee-for-service basis, which presupposes the identification of specific tasks or sets of tasks. In turn, these are (*en bloc*) part of the contracts between insurance funds at

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[18] The following paragraph is mainly based on the analysis of primary and secondary literature. However, the interviews with an officer from a provider association at state level, and with an officer of an insurance funds were very helpful in clarifying some of the issues.

state level and individual providers at local level. The provisions of the health insurance (§37, paragraph 2, SGB V) are less clear, and merely state that patients receive medically-related care (*Behandlungspflege*), if this is necessary to support medical treatment. As discussed below, here the scope of community nurses' practice is largely determined by office-based doctors, and their decisions about delegating care[19].

In summary, the role of purchasers in the governance of community nurses' practice predominantly consists of contractual agreements with providers. It could be argued though, that German contracts are in effect more influential, as they are accompanied by a fee-for-service system of reimbursement. This means that the services provided are more transparent. In contrast, in the British locality the GP consortium receives a fixed budget from the health board, and the contract only defines the number and type of staff which will be purchased within this budget. In the British locality contracts are completed at local level, whereas in Germany the negotiations take place collectively and at federal/state level. The influence of the GP consortium is much more direct in its nature, and it is strengthened by GPs' co-role as providers. The influence of the insurance funds in Germany is filtered by legal provisions and multiple layers of contractual agreements, and is more standardised. It is also restricted to a particular type of care. As a result of its contractual character the influence of purchasers in both countries tends to take the form of standard procedures rather than *ad hoc* arrangements. However, in the British locality this is likely to be complemented by informal decisions, as the purchasers are also involved in the provision of services, notably as GPs. As such, they directly interact with community nurses.

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[19] For more details see the discussion of different aspects of medical dominance later in this chapter.

Local providers

As discussed above, the role of local providers in the governance of community nurses' practice varies, reflecting different institutional contexts. In Germany, it is confined to the organisation of community nursing services, while the provider organisations at state level negotiate contracts with the insurance funds[20]. In the British case, both types of responsibilities are in the hands of the local trust.

In addition, at a formal level, job descriptions are a potentially important means of influencing practice, especially in order to distinguish between the scope of practice of staff with different levels of training. However, the senior manager of the German provider explained that the job descriptions are usually drawn up by the team leaders. Moreover, they appeared to be of little relevance in practice: one of the community nursing teams not even being sure whether they existed. In the British locality, the views on the significance of job descriptions varied: a member of one of the district nursing teams, for example, felt that job descriptions are rather outdated.

> "We do have job descriptions ... ." "But it (the job description) does not fit the description of the job any more."
> (exchange between two members of the team)

Similarly, the locality director emphasised that job descriptions become less relevant, the longer somebody is in the job. He put forward a more flexible model, arguing that the practice of district nurses develops alongside other areas of community care, especially GP services. Even the nurse manager, who plays a key role in drawing up job descriptions stressed their ambiguity. Moreover, the local providers in both countries have drawn up standards and policies on the delivery of domiciliary care, but they hardly featured in the interviews.

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[20] Although the German system is more centralised, the local providers remain formally independent. The respective peak associations at state level do not have any powers to impose policies beyond the level of contract.

Interestingly, in the British locality, while acknowledging the trust's influence, there was a sense among all interviewees that district nurses practise independently. The locality director, for example, presented a minimalist version of the trust's influence.

> "... (With respect to) professional practice, the trust has the responsibility for seeing each individual nurse fulfils their commitment to the UKCC to develop their own practice. And one of the jobs of the nurse manager is to review their (district nurses') performance in terms of the amount of work they do, and also the quality of the work they are doing and also listening to their aspirations in terms of training and so forth and articulating those on behalf of the locality."

Similarly, the nurse manager stressed that apart from the responsibilities of the trust as the employer of district nurses, it does not have any direct influence on their practice. These views were shared by both district nursing teams. A member of one team said that the nurse manager did not have a lot of influence on district nurses' practice. The team was considered to have greater impact. Although the other district nursing team was more aware of the ways in which the trust influenced its practice, it stressed its independence.

There was even some indication that the notion of professionalism and the ultimate accountability to the UKCC gives district nurses an opportunity to resist the determination of their practice from outside. A member of one district nursing team expressed uneasiness about the recent changes, and argued that there are limits to the expansion of practice, in that district nurses have to protect their professionalism. The locality director added that the UKCC Code of Conduct was sometimes used as an argument not to perform certain tasks[21]. Similarly, a member of the core group of the GP consortium argued that although it is the responsibility of the trust to ensure that nurses are adequately trained, she acknowledged that it is difficult to force nurses to perform certain tasks. This reflects the district nurses' dual commitment to

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[21] The UKCC Code of Professional Conduct (1992: 5) states that in exercising professional accountability registered nurses must "... acknowledge any limitations in your (their) knowledge and competence and decline any duties or responsibilities unless able to perform them in a safe and skilled manner."

the UKCC as their professional body, and to the trust as their employer. Further, the insistence on the professional obligation of district nurses challenges the validity of the contract between purchaser and provider, and thereby also questions the external determination of their practice.

In summary, in the British case the local provider, together with the local purchaser formally define the scope of district nurses' practice. Interestingly, however, the actors in the British locality ultimately perceived the practice of district nurses to be relatively independent of the influence of local providers. In contrast, the role of the local provider in the German locality is confined to the organisation of service delivery. The local providers in both countries have made attempts to formalise community nurses' practice by drawing up job descriptions and clinical standards, although these do not seem to be particularly influential in practice.

Doctors - professional and organisational aspects of dominance

So far, it has been suggested that contractual negotiations between purchasers and providers (together with legal provisions in the case of Germany) assume a central role in the governance of community nurses' practice. However, in the following it is argued that these are complemented by case-by-case decisions as part of the process of delegation/referral by office-based doctors. This points to medical dominance, although it manifests itself in different ways, reflecting the respective institutional contexts.

The role of office-based doctors in the provision of health care differs[22]. In Britain, general practitioners are in the position of 'gatekeepers', and patients have to register

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22 In order to acknowledge the different roles played by doctors practising outside hospitals in each country different terms are used. British doctors are referred to as "general practitioners", whereas their counterparts in Germany are described as "office-based doctors". In the case where both countries are referred to, the more generic term of office-based doctor is used.

with a GP practice, in order to be referred to specialist and hospital services[23]. In contrast, in Germany generalist as well as specialist doctors (*niedergelassene Ärzte*) practice outside hospitals. Patients are free to consult any doctor although they need a doctor's referral to use hospital services. In some respects, community nurses in the German case depend on doctors' formal directives, although they operate quite independently in organisational terms. The situation in the British locality seems to be the reverse, in that the dominant position of GPs in organisational terms co-exists with district nurses' relative professional independence. This suggests the need to distinguish between organisational and professional aspects of medical dominance.

Compared to Britain, community nurses in the German case appear to be more detached from office-based doctors in organisational terms, while they are more dependent on them professionally. Community nurses operate independently from the services provided by doctors, and are not attached to a particular practice. This makes communication about the care of patients difficult[24]. At the same time however, it is the responsibility by law (*Sozialgesetzbuch V*) of the office-based doctor to assess the need for medically-related care (*Behandlungspflege*), and to decide whether or not to delegate it to community nurses. Office-based doctors, then, have the overall responsibility for the provision of medically-related care. This affects both the scope and the autonomy of community nurses' practice. Since about half of the care provided by community nurses is medically-related (Meyer, 1996), their dependence on doctors' formal directives is significant. Formally, the influence of office-based doctors does not extend to basic care (*Grundpflege*), which is covered by the long-term care insurance (*Sozialgesetzbuch XI*). Its provision is set out in a

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23 As discussed earlier the role of GPs is likely to increase in future in the context of a policy emphasis on a primary care-led NHS. This policy trend has continued under the Labour government with the introduction of primary care groups from effect of April 1999. For a more detailed discussion of the changing role of GPs see the analysis of the governance of the division of labour in health care in chapter 10.

24 In part, this also reflects the fact that the professional dependence is defined in legal terms. Thus, there is a lesser need for both sides to negotiate further their relationship.

contract between the patient and the local provider, and it is based on the respective legal and contractual provisions.

The ambiguity of the relationship between office-based doctors and community nurses in the area of medically-related care featured prominently in the focus groups with community nursing teams in Germany[25].

> "This (the relationship between office-based doctors and community nurses) varies and ranges from doctors ringing us (the community nurses) to get us new patients, to fighting a running battle, and the office-based doctor may not feel responsible for things which clearly fall into his remit ... . These are formal directives which we need to perform certain tasks."[26]

The degree of autonomy of community nurses' practice depends on how detailed the formal directives of doctors are. One community nurse explained that this varies: while some doctors leave it to the nurse to decide how to treat a wound, for example, others give very detailed instructions which sometimes even contradict existing nursing knowledge. Despite this professional dependence, office-based doctors and community nurses appear to be rather detached from each other in organisational terms, their contact being mediated through patients. One community nurse pointed out that it is often the nurse who has to ask the doctor to see a patient, or to order additional medically-related care. This was confirmed by a community nurse of the other team who argued that doctors often take very little interest in patients who stay in their own homes. Another community nurse also stressed that doctors often do not use the nurses' care records when doing home visits.

In comparison to their German counterparts, the position of the district nurses in the British locality appears to be the reverse, in that they have a closer relationship with

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25 Similarly, cf. Brandt *et al.* (1992: 178ff).

26 "Das (das Verhältnis zwischen Ärzten und Krankenschwestern) reicht von dem aus, daß die Ärzte hier (Sozialstation) anrufen und uns neue Patienten vermitteln, bis zu dem, daß so eine Art Kleinkrieg ist, daß der Arzt sich nicht zuständig fühlt für Dinge, die ganz sicher in seinem Zuständigkeitsbereich liegen ... . Das sind ja Verordnungen, die wir brauchen, um bestimmte Tätigkeiten auszuführen."

GPs in organisational terms, and a more independent one professionally[27]. The first aspect manifests itself in the attachment of the district nursing team to a GP practice[28]: the provision of district nursing services is restricted to the respective practice population, and the team is part of the local GP-based primary health care team. The district nurses, therefore, always have contact with the same group of GPs. This leads to a system of referral, whereby GPs refer patients to district nurses and vice versa. Here, besides face-to-face contact, the main means of communication are message books[29]. The important position of GPs in organisational terms is further strengthened by the fact that they also act as the purchasers of community nursing services[30].

However, at a professional level, the district nursing teams seem to be more independent from GPs than their German counterparts. District nurses do not depend on doctors' delegation of *specific* tasks as in the German case, but GPs refer patients, that is *cases*, to the district nursing team. It could be argued that this reflects the assumption that there is something like nurses' 'territory'[31]. Here, the following characterisation of occupational territories of doctors and nurses by the senior partner of one of the GP practices is indicative.

> "It is more an overlap, in, for instance, that we both would be getting into the house, ... we (GPs) will be supervising the medication, medical things, while the nurses will be supervising poor hygiene, feeding needs, bathing needs, catheterisation care. ... It is more of a 'side-by-side' rather than an

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27 It could be argued that the lack of a formalised relationship is compensated by a closer relationship in organisational terms.

28 One of the district nursing teams is attached to three practices, which are all in the same building.

29 The communication is further facilitated by the fact that the offices of the district nursing teams are in close proximity to the GP practice, the two groups being housed in adjacent buildings.

30 The role of the purchaser in the governance of community nurses' practice was discussed in more detail above as part of the analysis of process of purchasing earlier in this chapter.

31 Similarly, in their study of fundholding GPs Tinley and Luck (1998: 482) suggest that "... at the operational level, GP-fundholders' power is constrained because individual case assessments are of a necessity carried out by senior nurses."

> overlap. But we would be overlapping, in that we are both getting into the house."

Nevertheless, there are conflicts related to referrals. One of the district nursing teams was particularly concerned about issues related to the scope of their practice. Members of the team recalled situations in which the GP had asked the team to deal with cases which were not in the team's remit like looking after patients in private nursing homes. But when asked how much influence GPs have on the practice of district nurses the relevant senior partner said

> "Very little. Almost none. Their (district nurses') working routine is very much structured from nursing administration. They are given protocols about what they can and cannot do. ... We (GPs) can't really ask them to do some things which are outside the remit of their normal practice. And they will usually tell us very firmly ... . And because they are busy, I think we have to accept that. But if we had more input we could probably change the priorities ... something they are doing would go and something else would come in."

The different perceptions of the senior partner and district nurses are interesting: the senior partner's view may reflect a bureaucratic understanding of the relationship between GPs and nurses, in which both are seen as separate organisational entities. Alternatively, due to their subordinate position in the health division of labour district nurses may be much more aware of any infringements in their practice than is the case with GPs. The members of the other district nursing team focused on the extent to which GPs' referrals impinge on the autonomy of their practice. There was a general feeling that the requests accompanying referrals vary in their degree of detail, and that this depends very much on the individual GP. In contrast, the respective senior partner argued that the degree of detail reflects the clinical problem concerned.

In summary, there are different types of prevailing dependencies between nurses and doctors. While in the British locality organisational aspects of medical dominance are most important and are strengthened by the GPs' role as the purchaser, in the German case professionally-rooted dependence is central. However, in the German case the

situation may change in the future with the growing importance of basic care, where community nurses are also professionally independent from office-based doctors. In terms of explanation it has to be taken into account that the relationship between GPs and district nurses is based on contractual obligations, since GPs also act as purchasers. In contrast, the relationship between community nurses and office-based doctors in Germany is determined by professional hierarchies, which are legally codified. As a result, the relationship between the two is more formalised, and there is less need for further negotiation. In the British locality, there is no corresponding formalisation and there is greater necessity to negotiate relationships through closer organisational ties.

Discussion

The analysis of the governance of community nurses' practice began by examining the organisation of community nursing teams and the distribution of managerial responsibilities in particular. Teams are the basic level of organisation of community nurses' practice. While leadership in the district nursing teams in the British locality tends to be more collective in its nature, the approach in the community nursing teams in the German case tends to be single-handed. In part, these different emphases in the style of leadership appear to be related to the size and composition of the teams. However, this characterisation is relative as the two styles partly co-exist with each other. In terms of the modes of governance the contracts play an important role. As these complement legal provisions, and are completed at state level in Germany, the contractual negotiations are more standardised and centralised than in the British case, where they take place at local level. This suggests that following the importance of legalistic elements there is a closer relationship between different levels of governance in Germany, while the influence of governance at national level in the British case is more indirect. In both countries, governance by contracts is complemented by case-by-case decisions particularly by office-based doctors as part of the process of referral/delegation. These provide opportunities for doctors to

exercise their medical expertise vis-à-vis nurses. But as indicated, medical dominance manifests itself in different ways in Britain and Germany.

The role of different actors in the governance of community nurses' practice more specifically can be summarised as follows:

Figure 13.1 The role of different actors in the governance of community nurses' practice

	Britain	**Germany**
purchasers	• direct influence via contractual agreements, strengthened by co-role as GP-provider	• indirect influence via contractual agreements at state and federal level
providers	• involved not only in organisation of services but also in negotiation of contractual agreements	• role restricted to the organisation of services
doctors	• organisational dependence as prevailing mode of medical dominance; co-exists with relative independence in professional terms	• professional dependence as prevailing mode of medical dominance; co-exists with relative independence in organisational terms
community nursing teams	• variable	• variable

At a general level, in both countries the same set of actors is involved in the governance of community nurses' practice. However, due to differences in the institutional contexts their specific roles vary between the two countries: compared to the German case, the purchaser of district nursing services in the British locality exerts more direct influence. It operates at local rather than at state or federal level and it is also involved in the provision of services. The same applies to the local provider: in contrast to its German counterpart, the British provider unit has more direct influence on the scope of district nurses' practice as it is involved in the

negotiation of the respective contractual agreements. In both countries doctors practising outside hospitals play an important role in the governance of community nurses' practice. It is fortified by legal provisions in Germany, and purchasing powers in Britain[32]. Their role can be captured in the notion of medical dominance. Interestingly, it manifests itself in different ways in each country. While in the German case, dominance is primarily based on professional hierarchies, in the British locality the organisational aspects of dominance are particularly important. In contrast, the role of community nurses themselves appears to be variable. Legalism and the prominence of contracts seems to be biased against community nurses, as they are not a constituent party of the purchaser-provider split. While this particularly concerns the scope of practice, community nurses may be more influential in terms of how these services are provided. The provider and the district nursing teams in the British case even referred to the independence of community nurses' practice. But in both countries, nurses' influence is likely to be limited by the dominant position of doctors.

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32 GPs seem to use their managerial powers as purchasers to pursue their professional agendas as providers, notably to expand district nursing services, in order to reduce demands on their services.

14 Grade-mix

Against the background of the analysis of the actors and institutions governing the practice of community nurses, this chapter turns to the governance of grade-mix, focusing on decisions about the composition of community nursing teams. Here, "composition", denotes the mix of staff with different levels of training. The analysis begins by addressing the question as to how decisions about grade-mix are made and the institutional context in which they are taken. It suggests that micro-politics plays a central role, although reflecting different institutional underpinnings. Within the process of filling a vacancy, local providers formally take the final decision. However, they are subject to the influential role of GPs as purchasers, and financial pressures (and basic, legally-defined standards), respectively. In comparison, the role of community nursing teams is uncertain.

Decisions about grade-mix

The mix of different grades appears to be governed predominantly at the level of the locality. Following the importance of contracts at local level identified in the last chapter this is expected in the case of Britain, but is surprising in the context of the German locality. It reflects the fact that the respective legal provisions allow for scope at local level. However, while in the British locality provider and purchaser alike are involved, in the German case decision-making powers are largely concentrated in the hands of the local provider.

In Germany, the federal legislation provides a central framework for decisions about the grade-mix in community nursing and defines basic standards the local providers have to meet. With regard to basic care for example, the *Sozialgesetzbuch XI* (§ 71), in conjunction with joint agreements on quality assurance (Bundesanzeiger, 1996), requires local providers to be headed by a qualified member of staff and care to be provided under the supervision of a qualified member of staff. In theory, a provider

could consist of unqualified staff and one (qualified) nurse. In practice, however, this is unlikely as providers tend to offer medically-related care as well. The requirements for this type of care are much stricter, in that a provider has to have at least four qualified members of staff, a nurse manager (*Pflegedienstleitung*) and a deputy[1]. Further, medically-related care has to be delivered by qualified staff (*fachlich qualifiziertes Personal*). The significance of these requirements has been highlighted by the recent shift in the distinction between basic and medically-related care: in the past, community nursing care was in effect mainly financed by the health insurance funds. With the introduction of the long-term care insurance, the percentage of medically-related care has dropped significantly. This has lowered the overall requirements in terms of qualification. Further, the distinction between these two types of care has become increasingly politicised, as the expenditure of the health insurance has been rising, while the long-term care insurance has been making surpluses (cf. Grieshaber, 1997). The existence of legal requirements also means that governance at macro and micro-level is closely connected and changes in the federal legislation are more or less directly felt by the local providers. Against this background the leader of one of the teams argued:

> "The current developments imply that under supervision everybody can provide care. But in domiciliary care it is difficult to ensure this kind of supervision as staff work on their own in the patient's home. These (the political developments) are a step backwards in the context of care, motivated, in my opinion, by financial considerations."[2]

This was echoed by the senior manager who characterised the recent developments as the de-professionalisation (*Laisierung*) of community nursing.

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1 As the officer of an insurance funds explained these requirements are set out in the (standard) contracts between insurance funds and local providers.

2 "Diese Entwicklung, die wir jetzt hier beobachten können, die nimmt das (das Krankenschwestern Pflege 'gelernt' haben) einfach so mit sich, weil die sagen 'Unter Anleitung kann das (pflegen) jeder machen.' Und das Schwierige in der ambulanten Pflege ist halt, diese Anleitung zu machen. Weil eigentlich ist man (ambulante Pflegekraft) ja vor Ort alleine. Das (die politische Entwicklung) ist so ein bisschen ein regressiver Schritt in der ganzen Plegesituation, die meiner Meinung nach auf finanziellen Erwägungen basiert."

However, it could be argued that the legal requirements only set basic standards and that individual providers are free to maintain higher levels of qualification among their staff. As discussed below, this option is indeed chosen by many of the non-profit providers, but it is considerably challenged by existing financial pressures. These arise, for example, from the fact that the fees for basic care are lower than for medically-related care, and from the increased competition between providers. In addition, local providers are in a vulnerable position not only as they are financially independent, but also as their income is based on a fee-for-service system. Moreover, the grade-mix in community nursing is challenged as the long-term care insurance is not only subsidiary to informal care, but also positively sanctions this type of care[3]: besides benefits in kind, patients can opt for cash benefits (*Pflegegeld*), which 80% do (Klie, 1997a) and the money tends to be used to pay for informal carers.

In principle, the provisions of the federal legislation are specified by a general contract (*Rahmenvertrag*) at state level. In North Rhine-Westfalia, however, the general contract on basic care does not contain any substantive specification of the grade-mix in community nursing. It merely defines what is meant by "qualified", and states that not more than half of the staff of a provider should be part-time[4]. The provisions at state and federal level are part of the contracts (*Versorgungsverträge*) between insurance funds and local providers. Beyond these legal requirements, as the senior manager of the local provider explained, providers are free to choose whatever grade-mix they see fit:

> "Section 80 of the *SGB XI* is the main section on quality assurance and contains provisions about quality of process, outcome and structure. As part of structural quality assurance minimum requirements are defined for setting up a service providing domiciliary care .... And that's all. Anything beyond

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3 It could be argued that in this way the long-term care insurance reaffirms the traditional welfare-mix, notably that the majority of domiciliary has been provided by informal carers.

4 See §21, paragraph 2 of the Rahmenvertrag (without year).

> that is left open, provided that the standards for quality of process and outcome are met. ... Then a local provider can run its services as it likes."[5]

In summary, in legal and contractual terms grade-mix in community nursing is defined as a measure of quality assurance. In the context of *Sozialgesetzbuch V* and *XI* the approach to quality assurance is ambivalent, in that it combines bureaucratic and market mechanisms: legal provisions about grade-mix do exist, and they provide a central framework for decisions about grade-mix. But apart from the quality standards set out in the legislation, local providers have considerable freedom. In some ways this highlights the limits of formal/legal provisions: in order to be applicable to different local situations, they cannot be too detailed.

In comparison, the British case is more clear-cut. There are no detailed provisions at national level, and the grade-mix in district nursing is mainly determined at local level. While the respective health board has drawn up policies on the development of community nursing services[6], these allow for adaptation to local circumstances, and do not necessarily restrict the scope of local arrangements. Further, there are no formal provisions as the contract between the trust and the GP consortium only defines the kind of services to be provided and the number of staff in terms of whole-time equivalents[7]. Thus, grade-mix is determined by informal case-by-case decisions. In theory, the question as to how these services are provided and what kind of staff delivers them is mainly up to the trust. However, due to their presence at local level the GP consortium as the purchaser is also involved in decisions about grade-mix.

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5 "Der §80 (SGB XI) ist der Qualitätssicherungsparagraph, der zum einen etwas zur Prozeß-, Ergebnis- und Strukturqualität ausssagt. Zur Strukturqualität sieht er eben das vor, was zur Aufstellung eines ambulanten Pflegedienstes als Mindestvoraussetzung zu gelten hat ... und damit hat es sich, der ganze Rest kann so laufen wie er will, wenn die Prozeß- und Ergebnisqualität stimmt. ... dann kann so ein Pflegedienst arbeiten, wie er lustig ist."

6 To insure the anonymity of the locality in which the research was conducted no reference is made to specific sources. These are also not included in the bibliography.

7 As another interviewee pointed out, the underlying assumption is that as long as the numbers of staff does not change, the quality of services remains the same.

In both countries, decisions about grade-mix in community nursing tend to be taken when a vacancy occurs. In contrast, the coverage of long-term temporary absence due to sick or maternity leave was not perceived as an opportunity for experimentation, even though the grade of the replacement sometimes varies from that of the permanent post holder. Considering the external pressures local providers in both countries are confronted with, this is surprising, especially as vacancies are not frequent, reflecting low turn-over rates in the two localities. Similarly, even when vacancies occur, the local providers seem to take a cautious approach to altering the composition of community nursing teams. How can this be explained? At a general level, personnel issues are highly sensitive in their nature, and an aggressive strategy such as replacing qualified with non-qualified staff may prove to be counter-productive in the long-term. In addition, in Germany the senior manager as well as the officer from the relevant provider association at state level explicitly referred to the specific organisational culture of non-profit providers, and their commitment to a socially-acceptable (*sozialverträglichen*) approach to changing existing grade-mixes[8].

The views on what kind of criteria are used when decisions are made about filling a vacancy vary between actors. For the German locality, the senior manager explained that there is a "personnel plan" (*Stellenplan*), which sets out the number and the qualification of staff of the community nursing teams. However, the income of the provider cannot be forecasted as it is based on a fee-for-service system rather than a separate budget. Consequently, any long-term planning of personnel development (*Stellenentwicklungsplan*) is difficult and decisions are taken on a case-by-case basis instead. Against this background he presented a functionalist argument, and

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[8] It could be argued that the local provider's non-adversarial approach to changing grade-mix reflects the legacy of its formerly not contested, oligopolistic market position as a non-profit provider. This may be exacerbated by the providers' explicitly religious orientation. Here, Eberle (1993: 43ff) identifies the notion of service to the patient as a central element of the Christian notion of charity. The orientation of this type of provider, therefore, is dualistic: while it is part of the church, it is also integrated into the public responsibility for providing care (based on the principle of subsidiarity) (Eberle, 1993: 4).

emphasised that the current financial situation of the provider is the central (if not the only) criterion when taking decisions about filling a vacancy.

> "In practice, in the case of a vacancy we have to decide how to fill it sensibly. This particularly applies to the area of domiciliary care which has to pay for itself. In practice, this means that we deliver services which are then reimbursed. ... Every time there is a vacancy one has to think again, whether this (a replacement/a certain grade) is appropriate at this point in time, whether this is sensible, whether we can cope with it. This is a very important question, especially under the present circumstances of stagnating turnovers."[9]

But he acknowledged that the financial imperative is not necessarily absolute and that it is up to the provider to what extent his decisions follow the present policy trend to employ lower qualified staff. The criteria identified by the senior manager contrast with those of the community nurses. One of the team leaders stressed that an important consideration is whether a candidate fits into the team.

> "Because we are such a small team we really have to be able to rely on each other ... ."[10]

It is not surprising that the community nurses were less concerned with the financial implications of new appointments, as the overall financial responsibility lies with the senior manager.

Interestingly, the locality director and the nurse manager of the British trust put much less emphasis on financial considerations[11]. Instead, they distinguished between what

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9 "Praktisch schauen wir natürlich immer, wenn eine Stelle frei wird, wie diese Stelle am sinnvollsten wieder besetzt werden kann. Weil gerade dieser Bereich ambulante Pflege ist ein Bereich, der sich aus sich selbst heraus finanziert. Das heißt praktisch, daß wir konkrete Leistungen erbringen und daß diese Leistungen vergütet werden. ... Man muß sich jedes Mal, wenn eine Stelle frei wird, neu ueberlegen, ist das (die Neubesetzung/eine bestimmte Qualifikationsstufe) jetzt angebracht, ist das jetzt sinnvoll, können wir das überhaupt vertragen. Das ist eine ganz wichtige Frage, weil in der augenblicklichen Zeit, wir erleben stagnierende Umsätze."

10 "Da wir ein so kleines Team sind, da müssen wir uns unbedingt aufeinander verlassen ... ."

11 As in Germany, the trust is exposed to external pressures. However, these primarily appear to arise from increasing demands on care in community settings. Financial pressures may also be

criteria should ideally be applied, and what criteria are *de facto* used. The nurse manager, for example, argued that

> "We would be looking at the demography, practice needs, what the GPs want and what the district nurses think is the most important thing. More now, it is based on history."

This also suggests that the local provider is constrained by past decisions about grade-mix, which manifest themselves in institutional inertia. But comparing and contrasting different motivations underlying new appointments, a member of the core group of the consortium observed:

> "And often a vacancy is looked upon (by management) 'This is an absolutely wonderful opportunity to employ someone with a lesser grade to do much the same work. And if they (the new staff) don't do it all quite, well somebody else will pick it up.' And we (the GPs) would like to avoid that."

This suggests that GPs are more concerned with the implications personnel decisions have for the practice of nurses. The same interviewee also pointed out that skills rather than grades matter. Similarly, the senior partner of one of the GP practices explained that the priority of GPs is that a certain set and level of services are provided. This reflects their co-role as providers, who depend on community nursing services. The perception of the GPs was echoed by a member of one of the district nursing teams, who felt that the nurse manager is primarily concerned with changing the grade-mix, in order to reduce personnel expenditure. This gives an indication of the potentially adversarial relationship between management and community nurses[12]. Instead, she argued that decisions about new appointments should pay more attention to the implications of any changes for the practice of district nurses.

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less directly felt, as the remuneration of the trust is not based on a fee-for-service system, but on a separate personnel budget.

12 A member of one of the teams, for example, concluded her comments on recent controversies over issues of grade-mix as follows: "We really have not been a militant lot at all, ... (we have) done everything that has been asked of us, but lately, it is just going too far."

> "We have got quite a good skill-mix, here. They (the management) want it down to one district nursing sister per unit. And really and truly that won't work, unless your district nursing sister is going to be supernumerary, and she is just going to do supervision."

So far it has been suggested that the institutional framework in which decisions about grade-mix are taken is broadly similar in both countries: in the case of Germany, the legal provisions at federal/state level are central for the decisions by the local provider about grade-mix, but they also allow room for manoeuvre. In the British case, by comparison, decision-making more or less exclusively takes place at the level of the locality. Equally, in both countries vacancies are perceived as the main opportunity to change existing grade-mixes. The views as to what criteria are applied vary between actors: while the local providers emphasised the importance of finances, the characteristics of the area concerned or the views of other actors, GPs and community nurses were concerned with the requirements of practice, for example, whether a candidate would fit into the team or whether she/he has the necessary skills to cope with the job. In contrast, in the following the role played by individual actors in the governance of grade-mix is examined in more detail. Particular attention is paid to the mechanisms of influence, for example by membership of the interview panel or by consultation, and to the nature of the influence, that is whether it is *ad hoc* or a standard procedure.

Purchasers - between direct and indirect influence

The role of purchasers in the governance of grade-mix in community nursing differs: while the influence of the insurance funds in Germany is indirect, the GP consortium in the British locality is much more directly involved. This reflects the respective institutional framework in which decisions are taken: that is the fact that the insurance funds operate at state level, whereas their British counterparts are present at local level. The position of the GP consortium is also strengthened by its dual role as purchaser and provider.

The German insurance funds do not take part directly in the decision-making about filling a vacancy, but instead determine (together with the provider associations) some of the parameters which influence the decisions at local level. Besides the determination of fees this particularly includes the definition as to what constitutes basic and medically-related care. Another source of influence is the fact that in legal terms decisions about grade-mix are indirectly part of the quality assurance in domiciliary care. But here, internal measures by local providers take precedence over quality assurance by the insurance funds. The external quality assurance can either take place as part of routine spot checks or on the basis of complaints by patients (Brüggemann, 1997)[13].

In North Rhine-Westfalia, complaints by patients are the basis for assessments of the quality of care. If the complaint is considered significant the insurance fund would ask its medical advice service (*Medizinischer Dienst der Krankenkassen*) to carry out an enquiry[14]. The medical advice service would report back to the insurance fund which would then decide what measures the provider should take, in order to improve the quality of its services. However, the insurance funds have opted for a guarded role, and the officer of an insurance fund explained:

> "The second option is to conduct state-wide and routine quality assessments. However, there has been little progress in this respect in North Rhine-Westfalia because we (the insurance funds) are still negotiating how best to go about quality assessments. This certainly also has implications in terms of personnel. ... Ultimately, we (the insurance funds) are not interested in this (extensive and routine quality assessments) because measures of quality assurance are not supposed to have the character of penalties. ... If we do it (quality assessment), it should be advisory in its nature."[15]

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13 In principle, before completing a contract, the insurance funds can assess whether a provider meets the basic legal requirements. But as the officer of an insurance fund emphasised, in most cases this is done on the basis of the documentation submitted by the provider, rather in form a separate enquiry.

14 For an indication of how these checks might look in practice see Schwülke (1997).

15 "Die zweite Möglichkeit ist halt eben, daß man hergeht und flächenddeckend, sozusagen routinemäßig Prüfungen durchführt. Das ist hier in Nordrhein-Westfalen noch nicht weit gediehen, da wir (die Pflegekassen) uns hier noch in Abstimmungsprozessen befinden, wie wir

These arguments suggest that insurance funds have explicitly opted for a cautious role in quality assurance, partly also reflecting financial considerations[16].

In contrast to the insurance funds, the purchaser in the British locality plays a more direct role in decisions about grade-mix. Since the contract with the local trust does not contain any specific provisions, the main opportunity to exert influence is the process of filling a vacancy. The views as to the exact role of GPs differed. According to the locality director, the consultation of GPs is a standard procedure.

> "It certainly says formally in our contract that the GPs would be involved in the interviews of new community nursing staff being appointed to their practices. ... (Beyond that) I think any nurse manager ... who tried to make a decision about the nursing team without involving the GPs would be an idiot."

But from the experience of the nurse manager the extent to which GPs take an interest in these decisions varies considerably and so far, few GPs have sat on the interview panel. Nevertheless, she stressed the importance of GPs' purchasing powers.

> "(asked about who ultimately decides) I would like to say that I do, but I don't. I am bent to pressure of the GP. Not all the time. And certainly, if they (the GPs) want something quite ridiculous put in. But they are the people who pay the money to buy the service."

The GPs themselves had a more critical view of their role in appointing new staff. A member of the core group observed:

Qualitätsprüfungen am besten durchführen. Das ist natürlich auch mit personellem Aufwand verbunden. ... Das (die flächendeckende Prüfung) wollen wir (die Pflegekassen) im Grunde genommen auch gar nicht, denn die Qualitätssicherungsmaßnahmen sollen nicht den Charakter von irgendwelchen Strafmaßnahmen haben. ... Wenn soetwas (eine Qualitätsüberprüfung) passiert, dann soll das beratenden Charakter haben."

16 Further, it also has to be taken into account that in the case of Germany quality assurance itself is a relatively new field, which was only introduced in a systematic way with the creation of the long-term care insurance (cf. Brüggemann, 1997). In addition, as an officer of the provider association at state level pointed out, so far the insurance funds and the medical advice service in particular have mainly been occupied with the implementation of the long-term care insurance, and the assessment of the care needs of potential claimants.

> "Until the establishment of the consortium, absolutely nothing (GP input into the process of filling a vacancy). And since the establishment of the consortium it (GPs' input) varies, like most things in the health service vary."
>
> "It (the involvement of GPs) should be a more organised consultation but it tends to be knee-jerk."

In comparison, one of the senior partners had a more positive view and argued that GPs play a central role in appointing new staff: GPs are consulted before the job advert is drawn up, they sit on the interview panel and take part in the final decision as to which candidate is offered the post.

In summary, most interviewees agreed that GPs play an important role in the process of filling a vacancy, reflecting their power as purchasers. However, there was disagreement as to the precise extent of their involvement, and as to whether this is *ad hoc* or a standard procedure. While the locality management in particular described the involvement of GPs as a standard procedure and their influence as dominant, the views of the GPs were more varied. It was pointed out, for example, that the position and influence of GPs as purchasers has only evolved gradually and that their role in the appointment process still varies from case to case.

The scope of local providers

As a result of the weak role played by the insurance funds, and the scope allowed by the legal/contractual provisions in the German case, the local provider, in principle, has considerable freedom in determining the grade-mix, in consultation with the community nursing teams. In contrast, in the British locality the process of filling a vacancy is subject to a more extensive form of negotiation which particularly involves the GPs.

Within the local provider in Germany the senior manager has the overall managerial and financial responsibility for domiciliary care and assesses applications, shortlists

candidates, conducts interviews and takes the final decision on the appointment of new staff. Although the senior manager acknowledged his (formal) decision-making powers, he felt that *de facto* the scope of the local provider is limited. He argued that decisions about filling a vacancy are influenced by the financial situation of the provider. The latter is largely determined externally, by negotiations between purchasers and providers about fees, and the distinction between basic and medically-related care[17]. In addition, the senior manager admitted that the financial imperative is not absolute and that it is up to the provider to decide to what extent it goes with the policy trend.

> "From my point of view there has been a trend towards de-professionalisation (in domiciliary care). Nevertheless, there is always the question whether this (the current trend) still suits us, whether our expectations are still met. ... In contrast to other providers we have not considered making qualified staff redundant and to replace them with non-qualified staff."[18]

The room for manoeuvre can manifest itself not only in the ways providers change existing grade-mixes, but also in variations of fees.

Compared with the local provider in Germany, the managerial structure of the trust in Britain is more complex: the operational management of the locality consists of the locality director and the nurse manager. The former has the overall responsibility for the services provided in the locality, but as he pointed out himself, he only gets involved in the appointment process if there are problems. The managerial and

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17 But he pointed out that local providers have some influence via the respective provider association at state level. Its role, however, is ambivalent: while local providers are not accountable to the peak association at state level, the latter negotiates fees (*Vergütungsverträge*) and represents local providers at state level. But the officer of the respective peak association at state level argued that this might change in the future, with the state level assuming greater responsibility in ensuring that the provisions of the contract are met by local providers.

18 "Für mich hat schon soetwas wie eine Entqualifizierungsoffensive stattgefunden (in der ambulanten Pflege). Trotzdem stellt sich immer die Frage, ob das (die gegenwärtigen Entwicklungen) zu uns dann noch paßt, ob unsere Ansprüche da noch walten. ... Wir denken nicht darüber nach, was andere Träger gemacht haben, Examinierte 'rauszusetzen und die dann gegen Nicht-examinierte auszutauschen."

financial responsibility for district nursing services lies with the nurse manager, who (formally) takes the final decision on appointments[19]. As in Germany, then, the decision-making powers lie with one person. But in practice, the nurse manager has to share her powers particularly with GPs. She observed that on grounds of office she should take the final decision on new appointments, but in practice she has to consider GPs' views.

> "But I would like to think that it was me (who took the final decision). I would argue my corner, because I think I am the expert of nursing, not them (the GPs). But the point of the matter is, they are paying the service. If they are happy to pay for a G-grade, although the area does not need it, which is a waste of public funds, that's what they'll get."

The importance of negotiations, especially with GPs, was also reflected in the fact that the nurse manager, and the locality director put particular emphasis on "what should happen ideally", implying that something different may happen in practice.

The uncertain role of community nurses

In both countries community nurses are involved in the process of filling a vacancy. But the views differed as to the extent of their involvement, as to whether it is *ad hoc* or a standard procedure and as to how influential community nurses are, compared to the other actors. This suggests that the role of community nurses in the governance of grade-mix is uncertain.

The local providers both in the British and the German case argued that community nursing teams have a clear role in decisions about new appointments. The senior manager in the German locality explained:

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[19] In addition, there is the nurse director whose role is advisory in its nature. The locality director and the nurse manager explained that the nursing director does not have any formal decision-making powers, as she is not part of the operational management.

> "Staff are involved in the process of filling a vacancy in that all candidates have to be introduced to the team (community nursing team). ... Applicants always have to go on a round (of patients). The feedback from the respective member of staff is very important for me when deciding whether she (the candidate) fits in (the team). Especially, as I only have little idea what really happens in the domestic setting."[20]

The locality director in the British case expressed a similar view when prompted about the involvement of district nursing teams. Initially however, he had explained

> " ... and then you decide on the appropriate replacement. That is a discussion which goes on mainly between the local GPs, whose practice population you are mainly serving and the nurse manager, who may take a judgement on that, about the grade of staff involved and the hours that are required and how the job will work."

The reaction of the nurse manager was equally contradictory: she argued that decisions about filling a vacancy are the result of negotiations with GPs *and* district nurses, suggesting that both actors are equally influential. However, when talking about particular cases, she exclusively referred to GPs and their powerful position as purchasers. This suggests that even though GPs and district nurses may be involved in the decision-making in similar ways, the views of the former appear to be more influential[21].

Against this background, it is not surprising that the district nurses themselves had a critical view of their role in the appointment process.

> "Yes, consulted. But they (the management) have their mind made up before they consult you (the district nursing team) on what they want, and you don't have much say."

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20 "Mitarbeiter werden an dem Berwerbungsverfahren beteiligt, dergestalt, daß, wer immer sich bewirbt, sich in dem Team (Pflegteam) vorstellen muß. ... Bewerber müssen auch immer eine Runde mitfahren. Das ist für mich ein ganz wichtiges Entscheidungskriterium, die Rückmeldung der Kollegin, die sie (die Bewerberin) mitgenommen hat, ob die zu uns (der Sozialstation) passen könnte oder nicht. Weil, ich kriege das in Wirklichkeit nur schlecht mit, was in der häuslichen Umgebung passiert."

21 It will be interesting to see what difference the introduction of a commissioning group at locality level will make. As the nurse manager explained, the group will consist of GPs and nurses who will deal with issues related to staffing levels and grade-mix.

> "It's (consulting the district nursing team when filling a vacancy) purely their (the management's) politeness, I think."

However, a member of the other team felt that there is certainly more consultation than in the past. Another team member added that district nursing staff may be invited to sit on the interview panel. A member of the other team also referred to an incident where the team had succeeded in influencing the type of replacement and where it got two part-time instead of one full-time staff nurse. However, the other team also explicitly referred to the variability of their involvement: while in one case the team was only notified of the interview at short-notice, in another it was asked for its views even before the appointment process began. From the view of the district nursing teams, then, their involvement is perceived as uncertain at best. Moreover, the process of filling a vacancy again highlights the adversarial relationship with the trust, in that the locality management was seen trying to push through its agenda. From the perspective of the district nursing teams, thus, the process of filling a vacancy provides an opportunity to challenge managerial views[22].

Compared to their British counterparts, the community nursing teams in the German locality had a more positive view of their involvement in appointing new staff, although it was not entirely clear what this actually entails. One member of staff explained that shortlisted candidates are introduced to the team and that the team discusses whether they are suitable. In contrast, another member of staff argued that the team only takes part in the decision as to whether a candidate is offered permanent employment after a period of probation. Although there was a sense that the involvement of the team is limited, this was not necessarily perceived in negative terms. A possible explanation is that there is a much clearer sense of hierarchy, especially between the senior manager and the team leader on the one hand and the team on the other. This suggests that the teams did not necessarily regard decisions

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[22] Here, a possible explanation is that the changes envisaged by the nurse manager were regarded as part of a broader agenda of organisational change. Further, they have to be seen against the background of the adversarial climate created by the managerial reforms of the NHS since the mid 1980s and their radical ideological character (cf. Harrison and Pollitt, 1994).

about filling a vacancy as being genuinely their 'business'. Moreover, as the relationship to management tends to be less adversarial, the community nursing teams may feel less compelled, compared to their British counterparts, to get involved and to defend the position of their team. In the German locality, the decision-making is complicated by the ambivalent position of the team leader, who is somewhere in-between being manager and a care practitioner. Here, one of the team leaders for example, suggested that she is involved in the decision about new appointments although the senior manager takes the final decision.

In summary, in both countries the views differed as to how community nurses are involved in decisions about filling a vacancy. The extent of involvement appears to vary from case to case, and is not necessarily a standard procedure. Moreover, the views of nurses appear to be subordinate to those of the local provider in the German case, and to those of the trust and the GPs in the British locality. Consequently, when talking about what factors particularly influence their decisions, the local providers did not explicitly refer to the views of nurses.

Discussion

The analysis of the governance of grade mix is summarised by looking at the level and mechanisms of decision-making and at the actors involved.

Figure 14.1 Levels and mechanisms of governing grade-mix

	Britain	Germany
level	• no provisions at national level; policies at health board level are flexible	• federal legislation (partly in conjunction with contractual agreements) sets minimal standards; provided that these are met local providers are free to choose grade-mix
	• decisions are taken at local level	• within this framework decisions are taken at local level
mechanisms	• when a vacancy occurs negotiation between trust, GPs and district nursing teams	• when a vacancy occurs negotiation between local provider and community nursing teams

Despite differences in the macro-institutional framework the level of governance is broadly similar, and in both countries decisions at local level play an important role. This particularly applies to the British case, reflecting the absence of provisions at national or health board level. In Germany by comparison, the situation is more complex. Decisions by the local providers are somewhat restricted by the framework of legal provisions at federal/state level, which specify basic standards. As regards the mechanisms of governance, in the British as well as in the German locality, decisions about grade mix tend to be taken when a vacancy occurs and are subject to negotiation. In comparison to the German case where only the local provider and the community nursing teams are involved, in the British locality the negotiating process appears to take a more extensive form, both in terms of the range of actors involved and the extent of their involvement.

Figure 14.2 **The role of different actors in the governance of grade-mix**

	Britain	**Germany**
purchasers	• GPs are in a powerful position as present at local level and as they are also (professional) providers	• within the legal/contractual framework the role of the insurance funds is minimal
	• may take part at different points in the appointment process: may be asked for their views before the formal procedure begins, may comment on the job advert, may sit on the interview panel	• indirect influence as they determine parameters for decisions at local level (basic contracts, fees, basic vs. medically-related care); more direct influence as part of external quality assurance
	• involvement of individual GP practices rather than the consortium	
local providers	• nurse manager takes final decision on new appointments; but subject to pressures from GPs in particular	• senior manager takes final decision on new appointment; has considerable scope in determining grade-mix, but challenged by financial pressures
		• provider association at state level has indirect influence via the determination of fees
community nursing teams	• district nursing teams => may be asked for their views before the formal application procedure begins => may sit on the interview panel	• community nursing teams may give feedback to senior manager => either on shortlisted candidates which are introduced to them => or on staff who are offered permanent contracts
	• their views appear to be less influential than those of GPs	• their views seem to be subordinate to financial considerations

From a comparative perspective the involvement of the different actors in the governance of grade-mix varies. In the case of the purchasers in Germany, for example, the role of the insurance funds is restricted to indirect influence: through the negotiation of general contracts, fees and the distinction between basic and medically-related care, they only influence the parameters of decision-making at local level. However, in theory they can intervene more directly if the provider does not meet the quality standards defined by the respective contracts. In contrast, due to

their presence at local level and their other role as professionals, the GPs as the purchaser in the British locality can exert more direct influence. In the localities in both countries the local provider takes the final decision about appointing new staff. However, the nurse manager/senior manager is subject to the pressures from GPs and from financial considerations respectively. In Germany, the provider association at state level also exerts indirect influence, in that it negotiates fees with the insurance funds. The involvement of community nurses in the decision-making process appears to be uncertain in both countries, varying from case to case, and being subordinate to other factors. In summary, this suggests that ultimately the grade-mix in community nursing is determined by doctors in their combined role as professional providers and purchasers, and financial considerations (together with legal provisions) respectively.

15 The division of labour

The preceding chapter analysed the governance of grade-mix in community nursing, and suggested that in both countries negotiations at local level play a central role. These most frequently occur as part of the process of filling a vacancy and tend to be case-by-case-oriented rather than standardised in their nature. In the case of the British locality, GPs as the purchasers of district nursing services assume a particularly influential role. But in the localities in both countries the views of the community nursing teams seem to be subordinate to those of providers and purchasers.

In contrast, community nursing teams appear to be involved to a greater extent in the governance of the division of labour. Again, the concept of governance is operationalised by looking at decision-making, and the analysis begins by examining systems of allocating work and the kind of criteria applied. Particular attention is paid to situations which challenge existing patterns of the division of labour, such as the deterioration of the health of patients. The analysis indicates that the governance of the division of labour is strongly localised and that decisions at the level of the team as part of the day-to-day allocation of work play a central role. Subsequently, it is analysed as to who else is involved in the governance of the division of labour; that is, how the influence of community nursing teams compares to those of purchasers and providers. Here, it is emphasised that in the localities in both countries they only play a limited role, in part reflecting the nature of decisions about the division of labour. Finally, the conclusions provide a summary by looking at the levels and mechanisms of governance and the actors involved.

Decisions about the division of labour

Considering that decisions about the division of labour concern detailed issues about the practice of community nurses, it may not be surprising that they are

predominantly taken at local level, although this also reflects the features of the provisions at national/federal and state level. Here, decisions about the allocation of work at the level of the community nursing teams dominate over more formal mechanisms of governance, such as contractual/legal provisions or job descriptions. The corollary is the limited role played by purchasers and providers, discussed below. The following analysis, then, examines the ways in which work is allocated by the teams and the criteria used to distinguish between staff with different levels of training/qualifications.

Against the background of the features of domiciliary care it is not surprising that the allocation of work in the community nursing teams in both countries is based on geographical areas: the district covered by each team is divided into sub-areas, and each qualified (in the German case) and specialist (in the British locality) member of staff is responsible for one of those areas. The part-time, unqualified and non-specialist staff work alongside them. But the allocation of caseloads appears to be of much greater concern in the community nursing teams in the German than in the British locality.

In the case of Germany the governance of the division of labour is multi-layered: following the divide between *SGB V* and *SGB XI* the federal legislation distinguishes between medically-related care (*Behandlungspflege*) and basic care (*Grundpflege*). Whereas the former has to be provided by qualified staff, basic care only has to be delivered "under the supervision of qualified staff". This distinction has complex implications for the division of labour in community nursing teams and its governance, in that qualified staff can perform both types of care, whereas the remit of non-qualified staff is restricted to basic care[1]. As a result, there are considerable overlaps between what qualified and non-qualified staff can do. One of the team leaders, for example, explained that if a patient needs both types of care in one shift

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[1] In terms of grade-mix, there is a trade-off between the cost of employing qualified staff who are flexible and the cost of sending qualified *and* non-qualified staff to the same patient.

he/she is seen by one qualified, rather than by one qualified and one non-qualified member of staff. Recent developments have further complicated the situation, with medically-related care being increasingly defined as basic care[2]. Insofar, as the federal legislation provides a framework for decisions by the team, macro and micro levels of governance are closely connected. Thus, one of the team leaders observed:

> "In principle, it is pretty clear what medically-related and basic care are. But we experience very directly what currently happens at the level of (health) politics, notably that many aspects of medically-related care are defined as basic care."[3]

Interestingly however, this legal distinction does not necessarily appear to be reflected in the team's approach to decision-making. The community nursing teams suggested that the allocation of caseloads strongly depends on the health of individual patients[4]. One of the team leaders explained that highly-dependent patients with multiple illnesses are, in principle, not cared for by unqualified staff, except for short periods of time such as weekends. In contrast, as both team leaders pointed out, the care of the elderly, that is of patients who are elderly and disabled but not necessarily ill, is a clear territory for non-qualified staff. But a member of one team stressed that these decisions are not necessarily based on a set of explicit criteria.

> "The overall impression, but also feelings. It is impossible to put it (the decision) down to specific points, in that one would get out a catalogue, saying 'This point is reached, and therefore a qualified member of staff needs to see the patient.' One develops a feel for it (the type of staff a

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2 For a more detailed discussion of the relevant policy development see the analysis of the role of purchasers later in this chapter.

3 "Also, eingentlich ist es schon ziemlich eindeutig, was Behandlungspflege und was Grundpflege ist. Obwohl, was jetzt in der Politik natürlich passiert ist, und das erleben wir jetzt natürlich auch hautnah, ist das ganz viele Sachen der Behandlungspflege in die Grundpflege hineindefiniert werden."

4 The co-existence of task-based provisions by federal legislation and the scope at the level of the team appears paradoxical. In part, it reflects the fact that work is allocated on the basis of a *set* of tasks rather than individual tasks. Consequently, changes in the patient's health may change the *mix* of care required and this in turn may have repercussions on the division of labour among members of the team.

> patient needs) over time. ... Alternatively, one sees how a patient is cared for, whether this is satisfactory or not."[5]

This approach to distinguishing between the scope of practice of qualified and non-qualified staff is based on the assumption that non-qualified staff know their limits, and that they indicate when they feel that they cannot cope any longer.

> "Because they (the non-qualified staff) quickly reach their limits ... that (highly dependent patients) is simply too much for them. And they are often reminded to admit to that and to set their own limits. When they realise 'This is too difficult, I can't manage it, I don't feel that I can do it.' then they shouldn't do it."[6]

Confidence was also expressed about the functioning of this system of self-control and a member of one team, for example, argued that non-qualified members of staff are highly cautious about the scope of their practice.

> "... we are lucky that we have staff who are aware of their limits. Thus, we do not constantly have to fear that there is somebody who continuously goes beyond his/her limits. ... Personally, I think that these staff allow for a high degree of security: I know that they will tell me if there was something out of the ordinary, even if it was only something minor ... ."[7]

In this context it is also interesting that the concept of qualification was mainly defined in terms of experience rather than formal qualification. Although the legal distinction between what qualified and non-qualified staff can do was acknowledged,

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5 "Gesamteindruck, aber auch so vom Gefühl her. Man kann das jetzt nicht so an speziellen Punkten festlegen, daß man einen Katalog 'rausholt 'Aha, jetzt ist dieser Punkt überschritten, jetzt muß eine Examinierte hin.' Das merkt man halt im Laufe der Zeit. ... Oder man sieht ja auch wie die Patienten versorgt worden sind, ob das da klappt oder nicht."

6 "Weil die (die Nicht-examinierten) auch schnell überfordert werden, ... das (Schwerpflegebedürftige) ist dann einfach zu viel für sie. Und es wird auch immer wieder an sie (die Nicht-examinierten) appeliert, das auch selber zu sagen und ihre eigenen Grenzen zu stecken. Wenn sie selbst sehen 'Das ist mir zu schwierig, das schaffe ich nicht, das traue ich mir nicht zu.', dann sollen sie es auch lassen."

7 "... dann empfinde ich das als großes Glück, daß wir Leute haben, die sich ihrer Grenzen bewußt sind, daß wir nicht ständig in Sorge leben müssen, das da jemand ist, der kontinuierlich über seine Grenzen hinausgeht. ... Also ich finde, diese Mitarbeiter geben ein hohes Maß an Sicherheit, weil ich weiß, da kommt bestimmt eine Rückmeldung, wenn da irgendetwas aus der Reihe ist und sei es nur eine Kleinigigkeit ... ."

in practice the work experience of a member of staff appeared to be equally, if not more, important.

> "Yes and no (prompted about the importance of case-by-case decisions). But this (case-by-case decisions) rather concerns the care tasks which they (the non-qualified staff) are also legally allowed to perform. But the law also says 'Non-qualified staff are not allowed to give injections.' We certainly follow the legislation. ... We follow the legislation, what is allowed and what is not allowed, but we also consider personal qualifications, the maturity of the individual or his/her skills."[8]

Members of both teams also stressed that all non-qualified staff have considerable experience in the field, and even suggested that there is sometimes little difference between them and the qualified members of staff.

> "They (the part-time staff)[9] are often well settled in as they have been with us (the community care centre) for a long time. Through university we often have people who are with us for three, four and more years and who have come from similar occupational backgrounds ... these are staff who bring in their own experience and who simply have to get used to the job. In this respect they (the part-time staff), although not qualified, are almost equal (to the qualified staff)."[10]

> "But if we are talking about qualified staff we also have to include him, (points to part-time, non-qualified member of staff), although he is not qualified. But he has worked in a hospice ... ."[11]

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8 "Ja und nein (Fall-zu-Fall Entscheidung). Aber das (die Fall-zu-Fall Entscheidung) betrifft mehr so die pflegerischen Handlungen, die sie (die Nicht-examinierten) rein rechtlich natürlich auch dürfen. Aber es ist natürlich auch vom Gesetz vorgeschrieben 'Nicht-examinierte dürfen nicht spritzen.' Da halten wir uns natürlich schon dran an dieses Gesetz. ... wir gucken schon nach dem Gesetz, was darf man, was darf man nicht, aber auch nach der persönlichen Qualifikation und Reife des Einzelnen oder Fertigkeit."

9 The community nursing teams in the German locality tended to use "part-time" and "non-qualified" interchangeably.

10 "Die (geringfügig Beschäftigten) (sind) aber oft sehr gut eingearbeitet sind und schon lange bei uns (der Sozialstation) ... . Durch die Uni haben wir oft Leute, die drei, vier und mehr Jahre bei uns gewesen sind und ähnliche Berufe haben ... also durchaus Leute, die Erfahrungswerte einbringen und die dann noch eingerarbeitet werden. Insofern sind sie (die geringfügig Beschäftigten) fast gleichzusetzen, außer dem Examen."

11 "Wobei, wenn wir von Examanierten sprechen, dann gehört er (weißt auf einen nebenamtlichen, nicht-examinierten Mitarbeiter hin) auch dazu, obwohl er nicht examiniert ist. Aber er hat ja in einem Hospitz gearbeitet ... ."

Situations where the health of a patient who is also or mainly looked after by a non-qualified member of staff deteriorates, provide further insights into the nature of the decision-making process. A member of one team stressed that as soon as there is an indication that the health of a patient might deteriorate, qualified staff will go and see the patient. The question as to whether the unqualified member of staff can continue looking after the patient depends on various factors. Referring to a particular case, a member of one team pointed out that this depends on

> "... how well he/she (the non-qualified member of staff) is used to the job. If he/she knows the patient well, if the relationship is good then he/she will continue (to care for the patient), and will be shown how to move the patient."[12]

In summary, besides (or even despite) the distinction between medically-related and basic care, decisions about the division of labour between qualified and non-qualified staff are made on a case-by-case basis, with the health of the patient and the skills of the member of staff being central criteria[13]. Together with the comparatively large size of the teams and the high number of unqualified staff, the reliance on 'soft' criteria leads to a considerable concern with decisions about the division of labour. The informal nature of governance, that is the importance of case-by-case decisions at the level of community nursing teams, is enhanced by the fact that the local provider does little by way of formalising the division of labour, for example as part of job descriptions[14].

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12 "... wie gut derjenige (nicht-examinierter Mitarbeiter) eingearbeitetet ist. Wenn er den Patienten sehr gut kennt, die Beziehung sehr harmonisch ist, da läßt man da jemanden (den nicht-examinierten Mitarbeiter) etwas länger und lernt ihn ersteinmal an in Lagerungstechniken."

13 Decisions about organising cover in cases of temporary absence are similar to those following changes in the health of the patient. Besides the patient's care needs decisions are based on how long a potential cover would have to travel to the patient, on who has time and knows the patient best, and on the preferences of the patient him/herself.

14 For a more detailed discussion see the analysis of the role of local providers in the governance of the division of labour later in this chapter.

In the British case, there appears to be even greater scope for local decisions about the division of labour. At national level, the UKCC's Code of Professional Conduct only lists procedural aspects of professional practice, stressing that staff should only take on those tasks they feel qualified to do[15]. It does not describe then, what staff with different levels of training can do and it also does not apply to non-qualified staff. But in comparison to the German case, decisions about the division of labour appear to be much less of an issue in the British locality. Here, it has to be taken into account that nursing auxiliaries account for significantly less than half of the team[16]. Further, their role is primarily defined in terms of a set of specific tasks.

> "They (the nursing auxiliaries) were very oriented towards the bathing. ... We tried to change things a little to do simple dressings and some pressure relief and things like that. Eye drops. You know, just to introduce another dimension to their job."

Moreover, there also appears to be a clear sense of hierarchy in that the scope of practice of non-qualified staff is determined by the G-grades[17].

> "... we (the G-grade nurses) actually decide what she (the nurse auxiliary) is actually going to do. ... Well ... (the nurse auxiliary) is not a qualified nurse, she has no national training whatsoever. So we (the G-grade nurses) decide what she is going to do ... . We decide what's going to go on their (the nursing auxiliaries') route. They are simply carrying out our instructions."

This suggests that there is a clear sense of hierarchy between qualified and non-qualified nursing staff[18]. In part, it is fortified by credentialist strategies, in that the majority of nursing staff have a specialist qualification in district nursing. Thus, the

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15 For a more detailed discussion see the analysis of the governance of the division of labour in health in chapter 10.

16 In one of the teams the ratio is two out of seven, and in the other it is three out of nine.

17 Similarly, when one of the auxiliaries of the team was asked what her responsibilities were, it was one of the G-grades who answered (fieldnotes).

18 This fits into the analysis of the organisation of community nursing teams and the observation that the collectivist style of leadership in the British locality had hierarchical elements. For a more detailed discussion see the analysis of the governance of community nurses' practice in chapter 13.

criteria used to distinguish between qualified and non-qualified staff seem to be more formal.

Formally, there is a high degree of differentiation among qualified staff which is expressed in the grading system and its various grades for qualified staff. But in practice this differentiation does not necessarily appear to matter. In one of the teams, for example, the staff nurse and the district enrolled nurse work alongside the G-grade in a small sub-team (fieldnotes) and one of them has long-standing work experience. Equally, it was stressed that there were few tasks which are exclusive to G-grades. Besides formal qualification and work experience, formal training provided by the trust was seen as central.

> "There are certain things ... (the G-grades) are only allowed to do. All assessment visits must be done by a qualified district nurse. Syringe drivers must be done, set-up by a qualified district nurse. But once they are actually been set up, everyone who has been on the course and can change the syringe ... . This is trust policy and that's what we follow."

Further, in terms of the allocation of work among qualified staff, 'softer' criteria appear to be used:

> "There are obviously protocols like 'A district nurse must do the assessment visits.' ... and also 'The syringe drivers must be set-up by a qualified district nurse.' ... But as for the general workload, running on a day-to-day basis we (the G-grades) decide who will do what, on their (the staff's) capabilities."

Similarly, when talking about future changes in the grade-mix, the main concern was that the new staff nurses have little work *experience*, as they directly come from their first-level training. This was echoed by the other team when discussing the role of the only staff nurse[19]:

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[19] But it has to be taken into account that this staff nurse is in a very different situation compared to her colleagues in the other team, as she is the only qualified non-G-grade. Consequently, regardless of the extent of her experience, the distance to the other team members is likely to remain.

> "Perhaps we (the G-grades) are all more experienced. Our staff nurse came from a hospital-based unit which is very different from us and she is gaining a lot of knowledge. But she really herself admits that she does not have the experience ... and we encourage her to come back to us if she has problems, or if we think some things are changing we would not send the staff nurse into that situation ... ."

Although 'soft' criteria like skill or experience are applied, this does not appear to complicate decisions about the division of labour. A possible explanation is that the distance between differently qualified staff is less significant than that between qualified and non-qualified staff. Similar to the German case the importance of decisions at the level of the district nursing team is further strengthened by the fact that the trust has not adopted specific measures towards formalising the division of labour. This is reflected, for example, in the ambiguous nature of job descriptions[20].

In summary, in the localities in both countries decisions about the division of labour in community nursing are taken at local level, notably at the level of the team. The approach to governance is mixed and even ambiguous. Some decision-making happens on a case-by-case basis, with the health of the patient and the skills of the member of staff being the central criteria. Other decisions are subject to a certain degree of formalisation, notably the legal distinction between basic and medically-related care in Germany and a credentially-based differentiation between qualified and non-qualified staff in the British case. Nevertheless, there remains considerable scope at the level of individual teams, following overlaps between qualified and unqualified staff in the case of Germany, and between G-grades and qualified non-G-grades in Britain.

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[20] For a more detailed discussion see the analysis of the role of local providers later in this chapter.

Purchasers - between disinterest and influence from a distance

Compared to the community nursing teams the role of purchasers in the governance of the division of labour is limited, but it varies between the two countries. In the German case, insurance funds exert some influence, mainly through the important role played by legal/contractual provisions at federal level. Their British counterparts at local level, by contrast, seem to take little interest in decisions about the division of labour.

Following the strong legalistic element in the governance of internal boundaries in Germany, provisions at federal level play a potentially influential role. In this context the existence of the two separate legal frameworks of *Sozialgesetzbuch V* and *XI* and the corresponding distinction between medically-related and basic care are central. As part of the health care reform in 1997 the insurance funds seem to have a more active role in shaping the relevant legal/contractual framework. The legislation envisaged a list which would distinguish more clearly between basic and medically-related care (Dzulko, 1997). The insurance funds produced a draft of this so-called "*Abgrenzungskatalog*", but without consulting the provider organisations. The list re-defined many aspects of medically-related care as basic care (Häusliche Pflege, 1997). Not surprisingly, it proved highly controversial and was subsequently withdrawn. In conjunction with growing financial pressures on local providers, any such shift is likely to have significant repercussions on the division of labour within teams: the scope of practice which is exclusive to qualified staff is reduced, while that of unqualified staff expands. As a result, non-qualified staff are not only cheaper but increasingly they are also becoming more flexible[21]. A similar, but more direct type of influence arises from the fact that the health insurance funds have started to refuse to pay for certain types of medically-related care which patients or their

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[21] Here, it also has to be taken into account that the local provider units are relatively small and that they are largely financially independent. In addition, changes in the range of services covered by the insurance schemes directly affect the income of the local provider, as it is based on a fee-for-service system.

relatives have been asked to perform for themselves. The senior manager of the local provider, for example, referred to a case where an insurance fund had provided the patient with the equipment to take blood pressure instead of paying a fully-qualified nurse to do it[22]. Such a move has been supported by a recent court ruling, which introduced a distinction between "simple" and "qualified" medically-related care. Only the second type of care is the prerogative of qualified staff (cf. Klie, 1996). These two sets of developments have in common that they potentially also help to refine the legal distinction between different types of care. Finally, as in the case of grade-mix other potential sources of influence derive from the overall framework of quality assurance: if the local provider does not meet the standards set out in the legal and contractual provisions, the insurance funds may, together with the medical advice service, investigate the quality of services. This may include the division of labour among staff.

Compared to the case of Germany, GPs as the purchasers in the British locality appear to play an even more limited role and seem to take little interest in decisions about the division of labour[23]. Such a passive approach is surprising, in comparison to both the decisions on grade-mix and the German case. A possible explanation is that the GPs and the GP consortium respectively are mainly concerned with the *overall* management and provision of services, and are reluctant to get involved in nitty-gritty turf battles within the teams. The seemingly active role of the German insurance funds fits into this interpretation, as it represents indirect influence from a distance. The insurance funds not only operate from federal and state level, but their influence is also diffused by the fact that it is part of the implementation of federal legislation.

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22 The underlying argument is that medical delegation only requires that the delegate is *able* to perform a task, but not necessarily that she/he is *qualified.* Nevertheless, this clearly departs from past practice and represents a generalisation of the principle of medical delegation.

23 The senior partner of one of the practices explicitly said that GPs do not have any direct influence on how work is allocated at the level of the team.

The limited role of local providers

The role of the local providers in the governance of the division of labour is paradoxical: within the framework of the legal/contractual provisions in Germany and due to the absence of provisions at national and/or health board level in the case of Britain, the local provider has the scope to decide what staff with different levels of training can do. However, the local providers in both countries seem to have done little by way of formalising the division of labour, for example as part of job descriptions. Their role, then, appears to be rather limited and, as in the case of the purchasers, influence is indirect in its nature. Possible explanations are that local providers, also, see grade mix as the main avenue of influence, whereas the day-to-day allocation of work may be perceived as the domain of the community nursing teams. Moreover, in the British case this is amplified by the notion of the independence and autonomy of community nurses' practice[24].

In the German case, as the officer of an insurance fund explained, as part of the measures of quality assurance the local provider is responsible for ensuring that staff are adequately qualified for what they are doing. In practice, its role seems to be limited and focuses on three aspects: indirect influence is exerted through the overall organisation of services, that is the distinction between the *Mobiler Sozialer Dienst* and the *Sozialstationen*, that is the community nursing teams. While the former exclusively provides domestic care and employs non-qualified staff, the latter focuses on basic and medically-related care. Further, as the senior manager explained, from time to time he checks that each service looks after the appropriate type of patients. Finally, he suggested that his influence on job descriptions is limited, as these are mainly drawn up by the team leaders.

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[24] For a more detailed discussion of this aspect see the analysis of the role of providers in the governance of community nurses' practice in chapter 13.

In the British locality, the views as to the influence of the trust on the division of labour in district nursing differed. Since there are no detailed provisions at national or health board level as to what individual grades can do, in principle the role of the local provider is greater. This was echoed by the nurse manager who argued that ultimately it is the trust which decides what individual grades do. But she added that in drawing up job descriptions, the policies of the UKCC and the health board, as well as the developments in other trusts, are taken into account. Although she plays a key role in drawing up job descriptions, she acknowledged their ambiguity. Moreover, the nurse manager pointed to the potential variance of what individual staff can do.

> "But they (the district nurses) have a fair degree of autonomy, or should have. ... I think if people think they are competent to practise, provided that their skills are kept updated, or they are practising within how they feel safe, fine, let them go (ahead). ... The only things they can't do are certain prescriptions ... and dangerous drugs ... They can't do prescribing, they can't sign death certificates. But everything else, provided that they feel that it is within their scope of professional practice; there is no law that says they can't."

As part of this approach the trust also provides in-house training on specific skills such as operating syringe-drivers[25]. The nurse manager's view of the flexibility of roles was echoed by the locality director who referred to the blurring of boundaries between different grades[26].

> "That is the new way of looking at it (the boundaries between different grades). And indeed it is more complicated than that (referring to a chart), because you will get G-grades doing what D-grades do, at times. Some people perceive that as inconsistent and others would say that's flexible, that's dynamic, in relation to the environment. ... I don't think we have a choice, but to move to this (more flexibility). This has to be the right thing and therefore you get quite a cross-over between what the grades do."

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25 Thus the decision as to who gets what kind of training is another source of indirect influence.

26 A member of the core group of the GP consortium agreed with the locality director in principle, and emphasised that in practice skills are more important than grades. But at the same time, she stressed that *de facto* grades have become more rigid, reflecting the trust's concern with liability.

Discussion

The analysis of the governance of the division of labour in community nursing is summarised by looking at the levels and mechanisms of governance and at the role of different actors.

Figure 15.1 Levels and mechanisms of governing the division of labour

	Britain	Germany
levels	• there are no specific provisions at national level, as the UKCC merely defines procedural aspects of professional conduct; no specific guidelines at health board level	• legislation and contracts at state and federal level include provisions about the division of labour between differently qualified staff, as reflected in the distinction between basic and medically-related care
	• ultimately, what individual grades can do is decided at local level	• in the context of quality assurance local providers are responsible for ensuring that staff are adequately qualified for the tasks they perform
mechanisms	• predominance of decisions by the teams on the allocation of work; criteria used: qualification (for division of labour between qualified and non-qualified staff), experience and training (for division of labour among qualified staff)	• within legal/contractual context predominance of decisions by the team on the allocation of work; case-by-case decisions based on the patient's health, work experience, familiarity with the patient, formal qualification
	• formal mechanisms include job descriptions and the provision of additional training	• formal mechanisms include legal and contractual provisions and job descriptions

Following the legalistic approach in Germany, the federal and state level potentially play a greater role in the governance of the division of labour in community nursing than the corresponding levels in Britain. While the UKCC guidelines only include procedural aspects of professional practice, the federal legislation in Germany defines what tasks are exclusive to qualified staff. But ultimately, and within the existing frameworks, decisions about the division of labour are taken at local level in both countries. At the level of the localities, the teams and their day-to-day decisions about allocating work play a central role in terms of governance. Interestingly, the criteria used to distinguish between the scope of practice of staff with different levels of training vary: in the British locality the existence/non-existence of a formal qualification was central to deciding the interface between qualified and non-qualified staff. In the case of the division of labour among qualified staff, in common with the German locality, other, 'softer' criteria prevail, such as experience, familiarity with the patient or in-house training. Together with the size and composition of the teams, this leads to different levels of concern with decisions about the division of labour, and it is higher in the German than in the British locality.

Figure 15.2 **The role of different actors in the governance of the division of labour**

	Britain	**Germany**
purchasers	• take little interest	• indirect influence from a distance => decide on boundary between medically-related and basic care, and whether patients do certain types of medically-related care => potential intervention if quality standards have not been met
local providers	• ultimately decides what individual grades do • BUT influence via job descriptions, provision of additional training, is in effect limited	• ultimately responsible that division of labour meets agreed quality standards • BUT influence via dualistic structure of service provision, checking allocation of cases, job descriptions is in effect limited
community nursing teams	• within the given framework teams are free to allocate work	• within the given framework teams are free to allocate work

Compared to the governance of grade-mix the most striking feature is the important role played by the community nursing teams in decisions about the division of labour: within the existing framework set out at the national/federal, state and local level the community nursing teams are free to allocate work among themselves. In part, this reflects the nature of the issue at hand, in that the division of labour concerns the day-to-day practice of community nurses, while grade-mix is more strongly related to managerial concerns. This might also explain why the purchaser and provider are hardly involved. While the GP consortium seems to take little interest in decisions about the division of labour, their German counterparts assume a

slightly more influential role. However, it consists mainly of indirect influence from a distance, particularly the definition of the boundary between medically-related and basic care. The local providers in both countries are formally in an important position: in the British case it is up to the trust to determine what individual grades can do and the German provider has to ensure that the division of labour meets the agreed quality standards. However, beyond job descriptions, the organisation of services and the provision of additional training, the influence of the local provider appears to remain relatively limited.

16 The governance of internal boundaries in a comparative perspective

Chapters 13-15 analysed different dimensions of the governance of internal boundaries from a micro-perspective, thereby exploring decisions about community nurses' practice, grade-mix and the division of labour. The central questions were: firstly, how are internal boundaries governed? Secondly, who is involved? This chapter summarises and discusses the prominent themes which have emerged from the detailed analysis of the interview material[1]. Further, it identifies the similarities and differences between Britain and Germany with regard to the levels, modes and actors of the governance of internal boundaries. Here, it also draws on the macro-analysis of occupational governance, which provides further insights into the occupational governance of internal boundaries in the two countries. It can be summarised as follows:

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[1] For earlier versions of this chapter see Burau (1999a, b).

Figure 16.1 **The governance of internal boundaries in a comparative perspective**

	Britain	**Germany**
modes of governance	• mix of formalisation and micro-politics => division of labour: co-existence of micro-politics (allocation of work by team) and formalisation (credentialism/professionalism) => grade-mix: predominance of micro-politics (decisions about filling a vacancy) due to lack of provisions, politicisation => scope of practice: co-existence of formalisation (via contracts) and micro-politics (GPs' referral)	• mix of formalisation and micro-politics => division of labour: co-existence of micro-politics (allocation of work by team) and formalisation (legalistic definition of different types of care) => grade-mix: micro-politics (decisions about filling a vacancy) within framework of legally-defined basic standards => scope of practice: formalisation (legal and contractual provisions about basic care) and micro-politics (office-based doctors delegate medically-related care)
levels of governance	• localised => contracts at locality level => complemented by case-by-case decisions	• standardised => legislation at federal level => ambiguous role of case-by-case decisions at locality level
managerial actors	• key role in localised governance: => direct involvement at local level, particularly in grade-mix and scope of practice	• role is subordinate to legalism => indirect involvement at state and federal level through (contractual) negotiations, especially in division of labour, scope of practice; => more direct but unclear involvement of local provider
doctors	• institutionalised medical dominance => direct involvement in decisions about community nurses' practice; due to role as purchasers extends to grade-mix => manifests itself as organisational dominance	• institutionalised medical dominance => in case of medically-related care direct involvement in decisions about community nurses' practice; => manifests itself as professional dominance
community nurses	• uncertain role in local governance of grade-mix and scope of practice	• marginal role in legalism and contractual negotiations; uncertain role in local decisions about grade-mix
	• relative independence in decisions about division of labour, BUT influenced by external factors and decisions by other actors	• relative independence in decisions about division of labour, BUT influenced by external factors and decisions by other actors

In both countries, the predominant modes of governing internal boundaries are formalisation and micro-politics. In most areas of governance, formal provisions laid out in legislation or contracts, and case-by-case decisions by actors at local level exist side-by-side. But in comparison to the British locality, the formalisation through legalism in Germany is more standardised. Thus, micro-politics always takes place in the context of the relevant legislation. This is reflected in the discourse of local actors, who also seem to move cautiously within the given legalistic framework. In terms of the level, therefore, governance in Germany tends to be more centralised, whereas the role of case-by-case decisions at local level remains ambiguous. Governance in the British case, by contrast, is more localised, and contracts are completed at the level of the locality. Also, compared to Germany there is greater scope for micro-politics. The relative differences between Britain and Germany in the mode and the level of governance are also reflected in the role of the different actors. As managerial actors, the purchaser and provider in the British locality have a key role in the governance of internal boundaries, thereby reflecting the absence of standardisation through legalism. The influence of their German counterparts is subordinate to legalism, and confined to an indirect role. Comparing and contrasting the role of doctors, the importance of medical dominance in both countries is most striking, but as a result of the different positions of doctors in the institutions of health care, it manifests itself in different ways. The institutional context also affects the relative power of doctors, and due to their dual role as purchasers and providers, the influence of GPs seems to be more wide-ranging. Similarly, despite institutional differences, in both countries the role of community nurses in the governance of internal boundaries appears to be marginal, and uncertain at best. It seems to be confined to decisions about the division of labour, although even these are influenced by external factors and decisions by other actors.

In summary, the internal boundaries in community nursing are governed by "others", that is purchasers, providers and doctors. Governance stretches over different levels, but it tends to be more localised in the British case. Similarly, different modes of

governance exist side-by-side, although in the German case micro-politics seems to be constrained by formalisation through legalism.

Modes of governance - between formalisation and micro-politics

The modes of governance describe the ways in which decisions are made about internal boundaries. Here, the prevailing approaches are formalisation and micro-politics through case-by-case decisions by local actors. However in Germany, legalism is the central means of formalisation, while in the British case, contracts and credentialism are more important. In most areas of governance, formal provisions co-exist with case-by-case decisions by local actors. However, the relationship between formalisation and micro-politics is complex and varies between Britain and Germany. Thus the analysis of the two localities helps to refine further the understanding of micro-politics, whose importance has already been highlighted by the macro-analysis.

In Germany, legalism is the central mechanism of formalisation. Legislation at federal and state level contains provisions about the scope of practice, the grade-mix and the division of labour in community nursing (cf. Meyer, 1996). The legal provisions concerning the grade-mix set the (minimum) standards local providers have to meet. In the case of the division of labour, they consist of lists of tasks which are/are not exclusive to qualified staff. In part, they also define the scope of community nurses' practice. Here, the important role played by legalism is enhanced by the structure of credentials in community nursing. As discussed earlier, there are practically no nursing qualifications specifically focused on non-hospital settings[2]. Thus, the existing qualifications contribute little to the definition of community

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[2] See the analysis of nurses working in the community in chapter 12.

nursing[3]. This, in turn, allows legal definitions of domiciliary care to have greater weight in terms of outlining occupational territory.

In comparison, in the British case, formalisation is based on contracts and credentialism. Here, national legislation does not contain any specific provisions about district nurses' practice, the grade-mix or the division of labour. Instead, in the British locality, the scope of practice was defined by initial contractual agreements between the trust and the GP consortium. In contrast, in the context of the governance of the division of labour, formalisation is based on credentialism and an institutionalised notion of professionalism[4]. The definition of professional practice by the nurses' regulatory body, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) is only procedural in its nature (UKCC, 1992)[5], but it is quite influential, as it is combined with a differentiated structure of qualifications in community nursing. This helps to define and map out the occupational territory of nurses working in the community. Moreover, although the codes and guidelines of the UKCC do not apply to non-qualified community nursing staff, they do so indirectly. They highlight the distinction between qualified and non-qualified staff, especially as most qualified nurses have a specialist second-level qualification. A close connection between formalisation and micro-politics is also fostered by the authority the UKCC enjoys as a body of professional self-regulation (cf. James and Jones, 1992). In some respects, the important role played by credentialism and an institutionalised notion of professionalism is surprising. It

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3 More generally, it also has to be taken into account that the scope of the governance of nursing education is limited, as legalism is fragmented between federal and state level. In comparison, the governance by statutory self-regulation through professional bodies in Britain is not only more cohesive, but is also more extensive in its scope. For a more detailed discussion of the governance of nursing education see chapter 8.

4 In comparison, attempts by the local providers to formalise further decisions about the division of labour, for example, though job descriptions appear to be less influential. A possible explanation is that local providers do not consider these type of decisions as the main avenue for exerting influence. Instead, these are largely left to the teams. For a more detailed discussion see the analysis of the role of providers later in this chapter.

5 For a more detailed discussion of the role of the UKCC see the analysis of the governance of nursing education in chapter 8.

seems to contradict the thrust of the macro-analysis of the governance of the division of labour in health, which highlights the limited scope of formalisation and the importance of locally-negotiated roles (cf. Ramprogus, 1995)[6]. The evidence from the case study, however, only points to the *co-existence* of both modes of governance and it underlines the fact that credentialism/professionalism *help* to formalise decisions at the level of the team.

In some ways, these different types of formalisation in Britain and Germany also reflect the specific welfare state traditions in each country. Windhoff-Héritier (1993) describes the German case as highly legalised, whereas the British approach is more flexible, reflecting a non-legalistic administrative tradition. The last point is echoed by Feick and Jann's (1989) observations in their study of different policy styles. They argue that in Britain the degree of legal codification of policies (formalisation) is relatively low; the same applies to programming, that is the degree of regulatory density and precision. With regard to Germany, Dyson (1982, 1992) also points to the central role played by law and the notion of *Rechtsstaat*.

Legalism, credentialism/professionalism and contracts represent distinct ways of formalising decisions about internal boundaries in community nursing. However these co-exist with micro-politics. In the case of district nurses' practice in the British locality, for example, contractual arrangements are complemented by case-by-case decisions as part of the process of referral by GPs[7]. Furthermore, credentialism maps out the distinction between qualified and non-qualified staff, whereas the division of labour is ultimately decided as part of the day-to-day allocation of work at the level of the teams. Similarly, in the context of the governance of the division of labour in

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6 See chapter 10.

7 In comparison, there is even more scope for micro-politics in the context of decisions of *how* community nurses' practice is provided. To varying degrees, these are subject to decisions by office-based doctors as part of the process of referral/delegation, and to decisions by the community nurses themselves. In the British case, the last aspect is echoed by the concept of nurses' professional autonomy.

Germany, the legal distinction between medically-related and basic care defines which tasks are exclusive to qualified community nursing staff. While this leaves a large overlap with non-qualified staff, this is not unusual and it also features in the grading structure in Britain. However, as the legal distinction is not occupationally entrenched, it is complemented by micro-politics. As a result, there are intense discussions at the level of the community nursing team about the scope of practice of unqualified members of staff, particularly in instances where the health of a patient is deteriorating. These decisions are largely taken on a case-by-case basis, considering the needs of the patient, the experience of the member of staff and her/his familiarity with the patient. Nevertheless, they still take place in the overall context of the legalistic framework.

Levels of governance

Formalisation and micro-politics as the predominant modes of governing internal boundaries in community nursing are closely related to the level of governance. Formalisation by legalism, for example, typically takes place at macro level. Similarly, by definition, micro-politics concerns decisions at the level of the locality, involving the local provider, the purchasing organisation (in the British case) and/or front-line-practitioners. At the same time, the analysis also stressed that governance is not necessarily restricted to one level. Legalism as a macro mode of governance, for example, co-exists with micro-politics. Similarly, contracts may or may not be negotiated at local level. This section examines in more detail the relationship between different levels of governance and as such it is concerned with the centre-periphery relations in the governance of internal boundaries.

It is argued that in Germany, governance is more standardised, reflecting the prominence of legalism. This, in turn, means that the federal government has a significant role in the governance of internal boundaries. Thus, the role of case-by-case decisions at local level (micro-politics) remains ambiguous. In contrast, the governance in the British case is more localised and local actors are involved in both

contractual and informal decision-making. These observations seem to contradict the macro-analysis which characterised the occupational governance in Britain as cohesive and its German counterpart as fragmented. It is argued that this not only reflects the specificity of the governance of internal boundaries, but also points to the complexities and ambiguities of occupational governance. Further, it highlights the inter-connectedness of micro and macro modes of governance.

The levels of governance are closely related to the complex relationship between formalisation and micro-politics as the predominant modes of governance. In the case of the British locality, not only is there an area which is largely subject to local decisions (grade-mix), but the mechanisms of formalisation are also less centralised. Contracts, for example, are negotiated at the level of the locality. Further, the same actors who formalise decisions also take part in more informal, case-by-case decision-making. Thus, the boundary between formalisation and micro-politics is more fluid, and as result, there is greater scope for local decisions. The local actors, therefore, seem to have a greater sense of the relative independence of their decisions.

In the German case, by contrast, legalism formalises decisions about internal boundaries from the centre; also, the strong element of standardisation inherent in legalism makes for a close relationship between the federal and local level. Ultimately, the scope of legal provisions is limited however, as they cannot account for all possible cases. In the context of grade-mix, for example, they set out the basic standards and they allow for more specific decisions at local level. Similarly, it is the local provider who is responsible for ensuring the quality of community nursing services. Meyer (1996) suggests that this reflects an explicitly dualistic approach, which combines legalistic and market mechanisms. Nevertheless, micro-politics is always overshadowed by legalism, and legalism seems to reinforce itself. Not only is the local discourse rich with reference to the relevant legislation, but the local actors also seem to treat legalism as the framework for their actions. This echoes Dyson's (1992: 9) observation that "It (the law) is built into the working world of policy. This

formal legalistic approach to policy is central to the regulatory culture of Germany". In part, the federal legislation is complemented by contractual agreements, but these also tend to be centralised. They take place at federal and state level, whereas the local providers are not directly involved.

However, in some ways the standardising effect of legalism in the German case seems to contradict the macro-analysis, particularly of the governance of nursing education and the management of nursing services[8]. Here, the prominence of alternative forms of governance, that is self-regulation and micro-politics, is directly related to the relative weakness of legalism, as reflected in a high degree of fragmentation (cf. Forschungsgesellschaft für Gerontologie, 1996). In contrast, the legalistic governance of internal boundaries is more cohesive and comprehensive. By virtue of being part of the basic contract with the local provider, the legal provisions apply to all types of providers, irrespective of whether they are religiously-oriented. Further, the federal framework leaves little scope for legislation at state level. So far, it has been argued that legalism limits the scope for governance at local level, as it defines more or less uniform standards. Further, it was emphasised that legalism is a *macro* mode of governance, formalising decisions about internal boundaries from the *centre*. This raises the question whether legalism in effect centralises governance. It could be argued that this is not necessarily the case, as the influence of actors at the centre is indirect. The role of the federal government as a law-maker, for example, is quite different from the power of the British government to set the budget of the NHS. However, in response to the challenge of cost containment, the governance by the federal government has become tighter and more intense (cf. Freeman, 1998b: 190). At the same time, health governance has been subject to stronger hierarchical elements in the form of direct state intervention and greater centralisation of decision-making, as reflected in the growing importance of the federal level (cf.

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[8] For a more detailed discussion see chapters 8 and 9.

Schwartz and Busse, 1997)[9]. Legalism, therefore, has explicitly been used by the federal government to extend its role in health governance, and the governance of internal boundaries is an example of this trend. Thus, in the current context legalism has strong centralist elements.

Equally, the relative absence of legalistic elements in the British case does not necessarily preclude centralist governance. Besides control of funding, there may also be tight guidance from the centre and decentralisation may co-exist with centralisation (cf. Allsop, 1995: 188). However, it seems that decisions about internal boundaries have been more open to local governance. Here, Buchan (1992: 22) asserts that the devolution of many aspects of the personnel function was a central element in the setting-up of self-governing trusts. It reflects the centre's rhetoric of the benefits of restructuring work organisation according to local circumstances (Grimshaw, 1999: 302). Nevertheless, local autonomy is also limited, notably by pressures from the centre to minimise labour costs in order to meet budget targets. The exercise of power by the centre, then, is indirect: it is mediated through budgets and is combined with an ideology of decentralisation[10]. Against this background, Pollitt *et al.* (1998: 9) characterise the NHS as a case of administrative devolution, whereby powers have been devolved, mostly from health authorities, to the newly created trusts. At the same time, political control and control over expenditure has remained with the centre, which has even sought to increase its influence. This trend of (centralised) decentralisation is particularly well exemplified by the British locality, where a GP consortium acts as the locality-based purchaser.

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9 For a more detailed discussion see analysis of health governance in chapter 7.

10 The micro-analysis of the governance of internal boundaries, then, points to the ambiguity of the level of health governance more generally. While some areas of governance have experienced decentralisation, others have become more centralised. Similarly, while the autonomy of trusts is real, it is also limited, as trusts "... were essentially creatures of the statute, dependent on the government for the space in which they operated" (Pollitt *et al.*, 1998: 53). Similarly, Exworthy (1994), France (1996).

In summary, the centralised governance in Germany reflects the prominence of a legalistic framework. The role of local governance, thus, is ambiguous: although legalism leaves scope at local level, the local provider seems to think in terms of its limits. The more localised governance in the British case points to a variety of factors: they range from the absence of legal elements to the partly decentralised nature of health governance.

Governance and managerial actors

As the payers of services and the employers of community nurses, purchasers and providers play a potentially important role in the governance of internal boundaries. However, their involvement varies between different types of decisions. In both countries, decisions about the scope of community nurses' practice and particularly grade-mix seem to be treated as the main avenues to exert influence. The governance of the division of labour, by contrast, is largely regarded as 'nurses' business'[11]. More importantly, the role of purchasers and providers differs between Britain and Germany, reflecting the respective institutional contexts of health care. In the German case, their influence is not only indirect, but it is also subordinate to legalism. In comparison, the purchasers and providers in the British locality have a more powerful role, as governance is more localised and as there is hardly any formalisation from the centre.

In Germany, purchaser and provider organisations primarily operate at state and federal level, specifying some legal provisions through contractual agreements, and negotiating fees on a yearly basis. As part of the new health care legislation in 1997, for example, insurance funds and provider organisations were asked to draw up a list, distinguishing between basic and medically-related care. Their role in the governance

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[11] As discussed as part of the analysis of the role of community nurses below a possible explanation is that purchaser and provider organisations are either too distant from the local level, or they appear to be reluctant to get involved in detailed decisions about the division of labour among the members of the team.

of internal boundaries, therefore, tends to be more indirect in that they influence the parameters of decision-making at local level. Compared to their British counterparts, their role is also limited, as it is supplementary if not subordinate to the governance by legalism. Further, the negotiations between insurance funds and provider organisations are firmly embedded in a legalistic framework and they tend to be standardised (cf. Alber, 1992). As discussed above, the position of the local provider is ambiguous: the legal provisions allow scope for local decisions, whereas the limitations they impose appear to be more important. For example, although decisions about grade-mix and the division of labour ultimately rest with the local provider, external financial pressures and the decisions by the community nursing teams seem to be equally, if not more, influential.

In comparison, the local trust and the GP consortium seem to play a more influential role in the governance of internal boundaries. They negotiate contracts about the scope of community nurses' practice and take decisions about grade-mix. Here, the GPs as the purchaser are in a particularly powerful position, as they are also professional providers. Because they operate at local level, their role is more direct. Compared to their German counterparts, the influence of the purchaser and provider is also more extensive as the approach to governance is more localised: the relative lack of formalisation from the centre places greater emphasis on decisions at local level. Thus, the local managerial actors are at the centre of governance.

Doctors - manifestations of medical dominance

As part of the macro-analysis of the occupational governance of nursing, it was suggested that the uncertain or marginal role of nurses in health governance also reflects institutionalised medical dominance[12]. Health care is primarily defined as medical care, which manifests itself, for example, in the influential position of GPs in

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[12] See the concluding discussion of the analysis of health governance in chapter 7.

the provision of health care, and in the influential position of their German counterparts in the system of self-administration. In the context of the governance of internal boundaries in both countries, office-based doctors have particular influence in decisions about the practice of community nurses: that is the range of service and how they are provided. This is likely to occur as part of the process of referring patients in the British locality, and the delegation of medically-related care tasks in the German case.

However, while this confirms the wide-spread view of the subordinate position of nurses vis-à-vis doctors (cf. Davies, 1995), medical dominance manifests itself in different ways, reflecting specific institutional contexts. In the British locality, the dominant position of doctors is institutionalised in the influential role they assume in *organisational* terms, as purchasers and providers. Community nurses are not only part of the GP-led primary health care team, but their services are also purchased by GPs. These two roles of GPs as providers and purchasers are intertwined and they appear to reinforce each other (cf. Witz, 1994). It could be argued, for example, that GPs use their role as purchasers to pursue their agendas as providers: one way of addressing the increasing demands being made on them is for GPs to hand down part of their workload to district nursing teams (cf. Jenkins-Clarke *et al.*, 1998). As purchasers they are likely therefore to advocate the expansion of district nursing services. As a result of their dual role, and compared to their German counterparts, the influence of GPs extends beyond the scope of practice as it also includes decisions about grade-mix. This illustrates what North (1995) calls the fragmentation of management, whereby the interests of different groups of managers become more diverse.

In the German case, medical dominance expresses itself in the legally-codified superiority of office-based doctors' *professional* judgement. The respective federal legislation provides for little formalisation, instead it sets out the primacy of medical delegation. It is up to the office-based doctor to decide not only what kind of medically-related care a patient needs, but also whether to delegate it to community

nurses. This reflects the strong medical orientation of the health insurance. In principle, it only provides cover if an illness has been diagnosed by a doctor and it only pays for treatment if a doctor considers it necessary. Thus, nursing is not acknowledged in its own right (cf. Böhme, 1990). The importance of professional aspects of dominance is underlined by the fact that community nurses are quite separate from office-based doctors in organisational terms. They are not affiliated to certain practices and their contact with doctors is mediated through patients.

These observations echo the suggestions in the literature that the division of labour in health care, and the micro-politics governing it, are contingent phenomena (cf. Hughes, 1988; Porter, 1995). In this respect, the analysis of the governance of internal boundaries emphasises the importance of the specific positioning of office-based doctors in the institutions of health care. They shape the ways in which medical dominance manifests itself, gravitating towards either organisational or professional aspects of dependence. The comparison also highlights the fact that medical dominance is relative and contingent upon the institutional context in which doctors operate (cf. Freddi, 1989): while the influence of office-based doctors largely focuses on the governance of community nurses' practice, the power of the GPs in the British locality is more extensive, reflecting their additional role as purchasers. Similarly, office-based doctors in Germany have much less influence on basic care, as defined by law rather than medical delegation (cf. Igl, 1995).

Community nurses - niches of independence within overall uncertainty

So far, it has been argued that local providers, purchasers and doctors assume an influential role in the occupational governance of internal boundaries. What is the role of community nurses? Neither legalism nor contracts assign nurses a distinct role. On the contrary, contractual negotiations are biased in favour of purchaser and provider organisations. In both countries, the evidence from the micro-politics at the level of the localities is ambivalent: whereas grade-mix was treated as a managerial

issue, with the involvement of community nurses remaining uncertain, decisions about the division of labour tended to be seen as a nursing matter[13].

At a general level, the financing of health care through social insurance contributions in Germany gives preference to the interests of employers and employees. This is exacerbated by a corporatist model of decision-making at federal and state level, from which nurses are excluded (cf. Alber, 1990; Bräutigam and Schmid, 1996)[14]. More importantly, while community nurses are naturally more strongly represented at local level, their role in governance is limited following the standardising and centralising effects of legalism. This does not mean to say that community nurses are completely absent, but legalism and contracts do not assign them any distinct position. Further, in the context of local decisions about grade-mix, for example, the role of community nursing appears to be uncertain as it seemed to be subordinate to the financial considerations of the local provider.

In the British case, governance is much more localised, potentially allowing for more opportunities for nurses to get involved, although and as in Germany, nursing has been described as an area of non-decision-making (cf. Robinson, 1991). But, it could be argued that the increasing localism in this case renders the involvement of community nurses more variable, as it limits the ability of central government to intervene more directly and on behalf of community nurses (similarly, Witz 1994: 42)[15]. Also, with the purchaser-provider split, contractual arrangements have become more important, in the completion of which district nurses are not necessarily

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13 The same appears to apply to the governance of community nurses' practice: nurses' involvement is uncertain with regard to the scope of practice, which is determined externally by legislation, contractual arrangements or doctors. In contrast and apart from possible interference by doctors as part of the process of referral/delegation, community nurses seem to play an influential role in deciding how services are provided.

14 For a more detailed analysis of this point see the concluding discussion of the analysis of health governance in chapter 7.

15 For a more detailed discussion see the concluding discussion of the macro-analysis in chapter 11.

involved. In the British locality, for example, the initial specifications of the scope of district nurses' practice and the yearly contract on the volume of services are primarily negotiated between the core group of the GP consortium and the locality management. Beyond this formal arena of decision-making, the GP consortium and individual practices also have considerable influence on more informal negotiating processes, such as on filling a vacancy. Compared to the district nursing teams, the views of the GPs carry much more weight in terms of the final decision, particularly as they combine the roles of purchasers and (professional) providers.

In contrast, decisions about the division of labour appeared to be left to the community nursing teams themselves, and were regarded as a "nursing matter" in the localities in both countries. However, this label is deceptive, as it primarily refers to the level of *direct* involvement of other actors. Considering their detailed nature it is perhaps not surprising that the local provider (and purchaser in the British case) are reluctant to become involved. Moreover, they already exert indirect influence by determining, together with actors at other levels, the parameters of the decisions taken by the team. This includes decisions about the amount of funding available or about grade-mix. Similarly, the scope of practice of differently trained staff is mapped out by credentialism/legalism. Thus, while the allocation of workloads may be in the hands of the community nursing teams, their decisions are structured externally by the agendas and decisions of other actors. Interestingly, in the British case, reference was also made to the notion of professionalism and the independence of district nurses' practice[16]. A possible explanation is that professional autonomy is treated as sacrosanct at the level of discourse, whereas it is much less influential in practice. The reference to the notion of professional autonomy may also reflect the authoritative and influential position of the UKCC as the statutory body of

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16 There was no comparable reference in the German case. A possible explanation is that here occupational governance relies to a lesser extent on professionalism, but instead legalistic mechanisms are more important in terms of defining nurses' occupational territory.

professional self-regulation[17]. At the same time, nurses do not work in isolation and they are part of the wider settings of health care. These are the interlinking provision structures of the local trust and the GP practices in the locality. Thus, notions of professional independence may well co-exist with other modes of governance.

In summary, the role of community nurses in the governance of internal boundaries is marginal, and uncertain at best. Community nurses do not have a distinct role in either legalism or contractual negotiations. This spills over into the governance by micro-politics, where the interests of providers and doctors (and purchasers in the British locality) are more influential. In contrast, decisions about the division of labour appear to be a niche of independent decision-making by the community nursing teams. However, these decisions are also subject to external influence, through mechanisms of formalisation, or through the influence purchasers and providers exert at different levels of governance.

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17 This point emerged strongly from the expert interview conducted as part of the macro-analysis. For a more detailed discussion see the analysis of the governance of education in chapter 8.

CONCLUSIONS

The present study set out to understand how nursing as an occupation is governed in different countries. The research contribution of the study is three-fold: firstly, it adds to the understanding of nursing by adopting a comparative, multi-level approach. It shows that different health systems make for different modes of governance. It also emphasises that the process of governance is complex, not only involving a range of different actors, but also stretching across different levels. The study also secondly raises interesting issues for the future research agendas of theories of professions and, thirdly for the comparative analysis of health care. It argues for an analysis of occupations in the broader context of the governance of policy sectors, and for an analysis of health systems from a bottom-up perspective. Thus, the aim of this final chapter is to consider the contribution a comparative, multi-level perspective can make to the analysis of nursing[1]. Moreover, it discusses some of the central questions the study raises in the context of theories of professions and the comparative study of health care.

The comparative approach

The study began by arguing that while there is a lot of research on nursing and on the comparison of health care in different countries, there is little research combining the two. However, comparison can make a contribution towards the understanding of nursing: besides exploration, the systematic analysis of similarities and differences can raise more general questions about the ways in which nursing as an occupation is governed. Considering that theories of professions are often based on a generic understanding of expertise, the differences between countries are of particular interest[2]. This is also reflected in the choice of countries: Britain and Germany show

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1 For a discussion of the practicalities of a comparative, multi-level analysis see chapters 4-6 on the methodology of the study.

2 See the review of theories of professions in chapter 1.

differences with regard to the institutions of health care and these also influence the occupational governance of nursing. In short, the comparative approach contributes to the analysis of nursing in two respects: it stresses the variety of ways in which nursing as an occupation is governed and it emphasises the importance of health care institutions for shaping the occupational governance of nursing. Comparison highlights variety and is also a tool for exploring it.

At a general level, the comparative approach aims to explore, to evaluate and to explain. In the context of the study, the contribution of comparison is two-fold. First, it is a basis for exploring nursing in different countries. More specifically, the study presents a detailed analysis of nursing in Germany to an English-speaking audience. As such, it also puts the British case into context and emphasises its specific characteristics. Secondly, the comparative approach provides a lever for explanation. Here, the study highlights 'differences within similarities': while the objectives of governance are broadly similar, Britain and Germany differ in terms of the exact process and modes of governance. The institutional contexts of different health systems go some way towards accounting for the variation observed. However, the use of the comparative approach appears to be limited when analysing the most salient similarities of nursing across different countries. The macro-analysis and case study, for example, both stress that the occupational governance of nursing is largely 'other people's business', whereas the role of nurses is marginal, uncertain or variable. This pointed to two salient issues in nursing: its subordinate position in health care, and the corollary of medical dominance. But the comparison also identified *different* manifestations of the same phenomenon, as in the case of the dominance of doctors, and their institutional underpinnings. Therefore, it provides a 'middle-range argument', which suggests neither that everything is different, nor that everything is similar. Here, historical comparisons may provide further insights into the deeper structures and power relations underpinning the occupational governance of nursing.

Further, the comparative analysis of the occupational governance of nursing challenges a generic understanding of occupations and emphasises the variety of ways in which nursing is governed. The macro-analysis, for example, identifies classic professional self-regulation as only one among a range of different modes of occupational governance. Much more prominent are micro-politics, legalism and self-regulation by providers of health care. Also, by highlighting the importance of micro-politics both parts of the study suggest that the analysis of nursing needs to look beyond nursing. Decisions about internal boundaries, for example, tend not to be taken by community nurses on their own, but by a range of local actors. These include the local provider, office-based doctors and purchasers. Their struggles over providing community care, filling vacancies and allocating work determine the occupational governance of internal boundaries. This echoes Burrage *et al.*'s (1990) and Light's (1995) view that the development of professions can be best understood as a political struggle between key actors, rather than within a static framework of assumptions about professions.

At the same time the comparative analysis also stresses the institutional contingency of these struggles. In the British case, for example, the role of GPs in the governance of internal boundaries is particularly powerful as a result of their dual role as providers and purchasers. The influence of their German counterparts, by contrast, is largely confined to decisions about the practice of community nurses. This illustrates the argument that institutions are pointers to power: they operate as opportunity and constraint structures, privileging some actors over others (cf. Hall and Taylor, 1996). Here, the comparative analysis provides an opportunity to analyse more systematically the ways in which (different) sets of health care institutions influence the occupational governance of nursing. The macro-analysis, for example, characterises the approach towards governance in Britain as relatively cohesive, whereas its German counterpart appears to be more fragmented. It is argued that this is related to the different roles played by the central/federal government in health care. This also raises the more general question as to whether there are country-specific models of governing nursing. In this respect, the study identifies typical

mixes of localism and standardisation, with Germany being characterised by a strong legalistic orientation and Britain by comparatively weaker degree of formalisation. While the exploration of internal boundaries helps to illustrate key aspects identified by the macro-analysis[3], the case study approach militates against too wide-ranging generalisations. An alternative strategy would be to compare and contrast the observations of the study with the literature on country-specific ideal types of professions[4]. Although their relevance is limited by the fact that they are based on dominant professions, the comparative analysis of nursing has potentially interesting implications for the understanding of the relationship between occupations and the state. These are explored below, as part of the discussion of the implications for theories of professions.

The multi-level approach

In the introduction of this study, it was argued that there is little research which combines different levels of analysis. Theories of professions tend to focus on understanding professions from 'within themselves', and are often used to analyse the micro level of work and work organisation, whereas the comparative study of health care tends to focus on the macro level of systems. However, it was suggested that these two levels of analysis can complement each other: although nurses may be predominantly present at the level of occupational practice, they are embedded in the broader context of health care institutions and are likely to be affected by them[5]. Against this background, the macro-analysis of different dimensions of governance was complemented by a case study of the internal boundaries in community nursing. The underlying aim was to explore further the nature of governance, notably from a micro-perspective. In terms of evaluation, the central question is what contribution the multi-level approach makes towards understanding the occupational governance

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3 See the review of the multi-level approach below.

4 For a more detailed discussion see the review of theories of professions in chapter 1.

5 Also see the discussion of the analytical framework in chapter 3.

of nursing; and, more specifically, what additional insights the micro-analysis provides. The study not only emphasises the importance of micro-politics, but also highlights the inter-connectedness between micro and macro modes of governance. This suggests that governance is not exclusively located at one level and that a multi-level approach therefore, is particularly appropriate for capturing the nature of the occupational governance of nursing in its totality.

The macro-analysis stresses the importance of micro-politics, particularly in the context of managing nursing and the division of labour in health care. While this merely points to the greater importance of one level over another, the analysis also indicates their inter-connectedness, in that micro-politics reflects macro modes of governance. In the context of the governance of the division of labour in Germany for example, the scope for local decisions is also related to the fact that the respective legal provisions only define basic standards. Similarly, macro-institutions contain in-built elements of micro-politics, such as the decentralising aspects of the otherwise centralised health governance in Britain.

The case study of internal boundaries in community nursing aimed to substantiate these initial observations, and its contribution to understanding the occupational governance of nursing is two-fold: it explores in more detail the dynamics of micro-politics, and it examines more thoroughly its relationship with macro modes of governance. With regard to the first aspect, the macro-analysis had suggested, for example, that the role of nurses in local decisions about the division of labour in health care is variable. The case study of internal boundaries illustrates and qualifies this point. It emphasises that the influence of community nurses varies between different dimensions of governance, but that overall it tends to be weaker than that of the local provider, office-based doctors and purchasers. Here, the analysis of the relevant institutional contexts also provides possible explanations, ranging from the power of purchasers and providers as contractual parties (in the British locality), to the constraining effect of legalism (in the German case).

In addition the case study offers deeper insights into the relationship between micro and macro modes of governance. As part of the macro-analysis, for example, it argues that the relative cohesiveness of the occupational governance in Britain reflects the more centralised nature of health governance, whereas the relative fragmentation in the German case is an indication of the weak role of the federal government. The case study challenges these initial observations. In part, this reflects the specificity of the governance of internal boundaries, but more generally it also points to the complex interaction between different levels of governance. In the British case, for example, the considerable scope for decisions at local level is in some ways exceptional, but it also reflects the relative absence of centralist mechanisms of formalisation. Instead, the influence from the centre is indirect and combines budgetary constraints with a rhetoric of administrative devolution. In the case of Germany, community care is characterised by a particularly cohesive legalistic framework, but which more generally illustrates the standardising (and centralising) effects of legalism.

In summary, a multi-level analysis helps to broaden the understanding of nursing, as it can take account of the interlinking levels at which occupations are governed: the micro-perspective can illustrate observations made at the macro level, and equally the macro-focus on the institutions of health care can help to explain the dynamics of micro-politics. But the study goes even further and stresses the synergetic effects of combining the two perspectives: the (full) understanding of the occupational governance of nursing only emerges by looking through the lenses of the micro and the macro-level at the same time.

Implications for theories of professions

The study uses theories of professions in order to understand how nursing is governed in different countries, but it also raises interesting questions for the future research agenda of this body of literature. It makes an argument for analysing occupations in the broader context of the governance of policy sectors. This

emphasises that occupations are closely intertwined with the state and broader activities of governing (rather than independent). At the same time, this perspective stresses the potential importance of policy sectors for shaping the governance of occupations, alongside with or even opposed to national styles of governing[6]. The suggested approach requires a closer examination of the relationship between occupations and the state, and the role of other, formally non-state actors in the process of governing.

Theories of professions have conceptualised the relationship between professions and the state in different ways. These range from the notion of two separate and even opposing organisational entities to the construction of country-specific ideal types, acknowledging variation[7]. The present study examines the relationship between nursing and the state from the perspective of governance. It stresses that the ways in which nursing is governed vary and reflect the institutional context of different health systems. Insofar as institutions are manifestations of political choices, the study emphasises the important role played by the state, across different countries, in the governance of occupations. The prominence of the state manifests itself in the inter-connectedness of different levels of governing. While the more localised nature of governance in Britain, for example, seems to confirm the absence of the state in the Anglo-American ideal type of professions, micro-politics is not only part of a centralist rhetoric of administrative devolution but is also subject to tight budgetary and political control by the centre. Furthermore, the study highlights the myriad forms the influence of the state can take. These range from licensing professional self-regulation and allowing for self-regulation by the providers of health care, to encouraging micro-politics while retaining overall control, and setting standards through legislation. The study, therefore, stresses the importance of the state in the context of the governance of occupations and also emphasises the need for a more

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6 The echoes the salient question in the context of policy analysis, whether policies are determined by sectors or national styles (cf. Freeman, 1985).

7 For a more detailed discussion see the review of theories of professions in chapter 1.

differentiated understanding of its precise roles. Thereby it challenges dualistic distinctions between 'strong' and 'weak' states, as suggested by country-specific ideal types of professions (cf. Collins, 1990; McClelland, 1990)[8].

Moreover, the study argues that it is not sufficient to "bring the state back in", but that the analysis of occupations also has to go "beyond the state"[9]. This reflects the fact that besides the state, the occupational governance of nursing is also determined by other actors. These can formally be seen as non-state actors and include purchaser and provider organisations. This observation is not new, but echoes, for example, Alford's (1975) classic argument about the rise of "corporate rationalizers". However, while he conceptualises managerial actors as a threat, the present study argues for the adoption of a more inclusive perspective. The interests, strategies and relationships of these actors reflect the institutional context in which they operate, and as such, these actors are part of the governance of a given policy sector. This blurs the distinction not only between the role of state and non-state actors, but also between the governance of occupations and the governance of policy sectors more generally. Thus, the study makes an argument for broadening the analytical perspective, and for examining how the governance of occupations is influenced by the wider governance projects of which it is part of and how the governance of occupations contributes to the governance of a given policy sector.

Implications for the comparative study of health care

The study considered the institutional context of health systems in order to broaden the actor-centred understanding of nursing as an occupation. Equally, it raises

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8 Similarly, Johnson (1995: 16) suggests analysing professions from the perspective of the Foucauldian notion of "governmentality" and argues that "... we must develop ways of talking about the state and profession that conceive of the relationship not as a struggle for autonomy or control but as the interplay of integrally related structures, evolving as the combined product of occupational strategies, governmental policies and shifts in public opinion."

9 This echoes recent debates about the concept of governance, which stress the complex nature of governing, involving a wide range of actors, among them the state (cf. Rhodes, 1997).

interesting issues for the comparative analysis of health care. The study makes an argument for the analysis of health systems from a bottom-up perspective. This involves examining in more detail what difference institutional settings make at the micro level of health care provision and what implications this has for conceptualising health systems in a comparative context.

By adopting a multi-level approach, the study turned the comparative analysis of health care upside-down and asked how health systems affect the frontline-provision of services. Here, it could be argued that the micro-case study challenges existing typologies of health systems. While the German social insurance system, for example, tends to be characterised as decentralised and fragmented, from the perspective of local providers, legalism seems to go some way towards providing a common framework for decision-making. Similarly, while the British national health service is often described as centralised, local providers appear to enjoy relative freedom with regard to some decisions. Although these observations are closely related to the particular case studied, they raise questions about the working of institutions 'on the ground'. What does it mean for a local provider, for example, to operate within a legalistic framework? Does legalism limit the scope for local decisions? How does that compare to the impact of budgetary constraints and tight political control from the centre?

Hence in terms of the research agenda of the comparative analysis of health care, the study makes an argument for connecting the macro and micro-perspective, in order to understand better what difference different institutions make. This implies a review of the nature and importance of the macro-institutions of health care. Such bottom-up analysis of health care may also provide a basis for reviewing the typologies of health systems in a comparative context[10].

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[10] The suggested approach is echoed by recent trends in the comparative study of welfare. In her study of care of the elderly in Britain and Germany, Schunk (1996), for example, examines how different institutional contexts of welfare affect the outcomes for individuals. Similarly, Cooper *et al.* (1995) and Hetherington *et al.* (1997) explore how different systems of child

Towards revised research agendas

Beyond understanding how nursing is governed in Britain and Germany, the study aimed to review the research agendas of three different, though related strands of the social sciences literature. Firstly, in the context of the analysis of nursing, it makes a case for adopting a comparative, multi-level approach: as it identifies the variety of ways in which nursing as an occupation is governed; as it locates nursing within the wider institutional context of health care, exploring the ways in which health systems influence the modes of governance and the actors involved; and as it examines the interlinking levels at which nursing is governed. With regard to theories of professions, secondly, the study highlights the benefits of analysing occupations in the broader context of the governance of a given policy sector. This requires closer scrutiny of the role of state and non-state actors in the governance of occupations. Thirdly, the study emphasises that a bottom-up analysis of health systems can yield interesting insights into the difference institutions make. As such, it can also provide a basis for reviewing existing typologies of health systems. These are the three research agendas the study has tried to develop.

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protection influence the practice of social workers. Finally, from a theoretical perspective, Alber (1995) suggests understanding welfare regimes on the basis of the provision of services, rather than in terms of social transfers.

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9

Challenging Boundaries in Nursing: Some Preliminary Observations on the Reform of Community Care in Britain and Germany[1]

Viola Burau

Over recent years health care systems across Europe have experienced a renewed emphasis on care in community settings. These developments reflect not only demographic and epidemiological changes, but also the policy-driven trend towards de-hospitalisation. At the same time, community care has seen the introduction of market mechanisms. With their emphasis on efficiency and a contractual culture these reforms also affect nursing, and tend to formalise its practice. More specifically, they challenge the grade-mix and the division of labour in nursing, which are central issues to managers and professionals: with the growing financial pressures decisions as to who is in a team, and who does what are becoming more important. Similarly, these issues are at the core of the professional debate about what nursing is. This is often defined in terms of the practice of nurses: that is, what nurses do in comparison to other occupations.

Decisions about grade-mix and the division of labour concern the internal boundaries in nursing. Following neo-Weberian theories of professions (Parkin, 1979; Witz, 1992) these can be interpreted as a particular type of social closure. In general terms, social closure is defined as " ... the process by which social collectivities seek to maximize rewards by restricting access to resources and opportunities to a limited circle of eligibles" (Parkin, 1979: 44). Against this background the setting-up and control of internal boundaries can be understood as a measure to demarcate the occupational territory of the core of nursing from that of its fringes. Interestingly, these 'fringe care workers' "... form ambiguous satellites to the caring profession, being neither entirely distinct, nor entirely integrated" (Hugman, 1991: 94).

The chapter explores these issues by looking at district and community nursing in Britain and Germany respectively[2]. It begins by discussing the recent reforms of community care in both countries, and their significance for the internal boundaries in district/community nursing. It argues that current developments provide an interesting framework for analysis, as they challenge existing internal boundaries. Second, based on a case study it analyses how decisions about internal boundaries are taken, and who is involved. It suggests that different health care regimes shape the setting-up and control of internal boundaries in district/community nursing. Finally, the conclusions explore the implications of the study of the 'politics of internal boundaries' for the theoretical understanding of occupations and health care regimes.

The reform of community care

In Britain as well as in Germany, community care is a topical issue in terms of policy development. The debate about community care and the critique of institutionalised care dates back from the early 1970s, but has recently received new impetus: it is argued that demographic and epidemiological changes increase the demand for care in non-acute care settings[3]. It is supported by a trend towards de-hospitalisation, notably attempts to reduce the length of stay in hospitals in order to contain expenditure for acute care. Paradoxically, then, the potential expansion of community care takes place in a general climate of financial austerity.

In Britain, the higher political visibility of community care is reflected in the 1991 'NHS and Community Care Act'. It introduced an internal market: health and local authorities are now largely confined to the purchasing of community care, whereas the actual provision primarily lies in the hands of independent trusts. Another important feature of the reform is the complex division between health and social care. As a result, the interface, and the co-operation between different agencies and occupations has become more important. Further, the arena of community care has become more diverse, as the boundaries between different sectors of health care provision have become blurred: hospitals reach out into the community by providing out-patient surgery, post-operative care as well as acute services in patients' home (Ross and Mackenzie, 1996: 21). Further, in the context of the promotion of a 'primary care-led NHS' (Department of Health, 1996), GPs also assume an increasingly central role in the health service, and community care more particularly. This is reflected in the rising number of practice nurses employed by GPs, whose work partly overlaps with those of district nurses (Lightfood *et al.*, 1992: 3), and the fact that since 1993 GP fundholders can purchase district nursing services (Traynor and Wade, 1994: 3).

In Germany, while community care historically has been considered as 'social welfare' rather than 'social policy' (Dieck, 1994: 253f), recent years have seen important changes: in 1995 the long-term care insurance (*Pflegeversicherung*) was introduced. The central role in the financing and organisation of community care formerly played by local authorities was transferred to the new long-term care insurance funds (*Pflegekassen*). In contrast to the already existing health insurance funds, they not only negotiate contracts, but also have to ensure the overall provision of community care services (*Sicherstellungsauftrag*), and assess patients' care needs. Another central feature of German community care is the distinction between basic and medically-related care (*Grund-* and *Behandlungspflege*), which is based on different degrees of closeness to medical tasks (Korporal, 1986: 232). Following the introduction of long-term care insurance, this distinction has been fortified with these two types of care now falling into separate branches of the social insurance system. This has important implications for the internal boundaries in community nursing, in that the formal qualification requirements are much higher for medically-related than for basic care.

In terms of the significance of these changes for the internal boundaries in district/community nursing, it can be argued that in Britain the managerialist approach has lead to a greater 'transparency' of the division of labour in health care (Lightfood *et al.*, 1992: 21). Further, the "... division between 'purchaser' and 'provider' is likely to place greater emphasis on provider units on assessing the cost-effectiveness of employing various grades- and skill-mixes, with the emphasis on the need to meet purchasers' quality criteria at minimum costs" (Buchan and Ball, 1991: 3). This has to be seen against the background that personnel costs account for the majority of the NHS budget (Buchan and Ball, 1991: 3). As nurses are the single largest occupation in the NHS, they are a likely target for the review of existing grade-mixes. Similarly, in Germany the challenge to internal boundaries in community nursing mainly originates from a general climate of cost containment. As the long-term care insurance operates under tight financial constraints, there is little incentive to tighten qualification requirements or quality standards. In addition, there has been a renewed emphasis on the principle of subsidiarity: the long-term care legislation stresses that formal care is secondary to informal care. The insurance, therefore, only provides basic coverage, including financial support for informal carers. Consequently, it is not only the limitation of financial resources but also the professionalisation of informal care which pose a challenge to the internal boundaries in community nursing.

In summary, the emphasis of community care in conjunction with the concern for cost efficiency in both countries, then, has lead to attempts to formalise the relationships between purchasers, providers and professionals, that is to define the scope and contents of district/community nursing services, as well as to specify the staff providing these services.

The 'politics of internal boundaries'

The following analysis reports on a case study on community nursing care for the elderly. Whereas in Britain this type of care is primarily delivered by district nursing staff, in Germany a whole range of different community nursing staff is involved. The use of terminology, therefore, differs depending on which country is referred to. Where nursing in both countries is concerned the combined term of 'district/community nurses' is used. The case study focused on a community trust in Scotland, and a local provider in North Rhine-Westphalia. The fieldwork consisted of focus groups with two district/community nursing teams in each locality, and élite interviews with the management of the trust/local provider, with the GP-consortium and the insurance fund as the purchaser, and with the senior partners of the respective GP practices.

Determining internal boundaries

At a general level, the need to define internal boundaries in nursing arises from the fact that care originated from the private sphere, and as such was defined as an unpaid, female labour of love[4]. Subsequently, care has gradually moved into the public sphere of paid work. However, as feminist writers stress[5], this move has never been complete, and as a result the definition of occupational territory has been a salient issue in nursing. This section argues that the setting-up and control of internal boundaries in district/community nursing is achieved by formalisation in conjunction with micro-politics at the level of the local provider and teams. However, the means of formalisation differ between countries: while Germany is characterised by legalism, in Britain credentialism and a well-established notion of professionalism are central. These differences are also reflected at the level of micro-politics. As the notion of professionalism permeates all levels, in Britain decisions about internal boundaries tend to be formal[6]. In contrast, although in Germany legalism ensures a closer relationship between federal and local level, it does not provide a locally entrenched notion of the distinction between differently qualified staff. Decisions about internal boundaries, therefore, tend to be informal/*ad hoc*[7].

In Germany, legislation at federal, and to some extent at *Land* level contains provisions about the internal boundaries in community nursing. These are formulated in terms of minimum standards, and vary between different types of care. Insofar as these provisions are part of the general contract (*Versorgungsvertrag*) between the insurance funds and the local providers, the federal and the local level are closely connected. The important role played by legalism is enhanced by the fact that the structure of credentials in community nursing is characterised by a low degree of differentiation: that

is, a dualistic distinction between qualified and non-qualified staff. In contrast, British (legal) provisions at national level merely provide a general framework for district nursing services, and instead credentialism and a well established notion of professionalism are the central regulatory strategies. Thus, the procedural definition of professional practice by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC), as the regulatory body of nursing, is combined with a differentiated structure of qualifications in community nursing. Although the codes and guidelines of the UKCC do not apply to non-registered district nursing staff, the latter are affected by the professional/credentialist approach, as it draws a stark line between qualified and non-qualified staff.

Legalism and credentialism/professionalism represent two distinct ways of formalising internal boundaries in district/community nursing, but they only provide *frameworks* for decision-making at the level of the locality ('micro-politics'). The different approaches to formalisation also appear to influence the degree to which local decisions are *ad hoc* in their nature. In Germany, although legalism formally ensures a close relationship between federal and local level, these provisions are external to the practice of community nurses. The incomplete (mutual) permeation of legal provisions and practice is especially reflected in decisions about the division of labour. Despite the legal distinction between medically-related and basic care there are intense discussions at the level of the team about the scope of practice of unqualified members of staff. In contrast, in Britain the formalisation of internal boundaries via credentialism/professionalism reaches down to the level of the team. Consequently, decisions about the division of labour tend to be more formal, and as such assume a much less prominent role than in the German teams.

Understanding the dynamics of the 'politics of internal boundaries'

Against this background, this section examines in more detail the dynamics of the political struggle to set-up and control internal boundaries. It analyses to what extent the patterns of decision-making are determined by the wider institutional context of the health care regime in each country, or by factors specific to the locality. In both countries contractual arrangements play an important role in regulating district/community nursing services. Whereas this is an established feature of the health care regime in Germany, it is a more recent phenomenon in Britain, which is closely related to the introduction of the internal market. Decision-making, therefore, often takes the form of negotiating contracts, and tends to be formal as opposed to *ad hoc*. Despite these similarities the degree of standardisation as well as the level at which decisions are taken vary.

In Germany, following the strongly legalistic approach, decision-making is highly standardised. The federal legislation, that is the *Sozialgesetzbuch V* and *XI*, not only contains provisions about community nursing services, but also procedural regulation about the remit of decision-making processes and contracts at federal/*Land* level. Not surprisingly, these are highly standardised, and at the same time are dominated by the federal level. This is exacerbated by the fact that apart from the completion of the basic contract (*Versorgungsvertrag*) the local providers are not directly involved in the decision-making. In contrast, in Britain the situation is almost the reverse: due to the low degree of legal regulation decision-making tends to be more localised. National legislation merely provides a general framework, while more detailed provisions exist at the level of Health Boards. The Scottish locality of the case study provides a good example, and also illustrates the current trend towards decentralisation of the NHS: at the level of the locality a GP consortium acts as the purchaser of district nursing services, and negotiates and completes contracts with the trust. While the consortium receives funds from the Health Board, it has considerable leeway when it comes to the negotiations with the trust. In comparison to Germany, then, decision-making in the British case tends to be more localised, as it is much less standardised.

Interestingly, however, formal negotiation co-exists with *ad hoc* decision-making at the level of the locality, as contracts are not exhaustive in their nature. In the case of Germany it reflects an explicitly dualistic approach to the regulation of community care, which combines legalistic and market mechanisms. Although the long-term care insurance contains substantive provisions, these take the form of minimal standards, and allow for considerable leeway at local level. The meaning of legalism at local level, then, is paradoxical: the strong element of standardisation inherent in legalism ensures a close relationship between federal and local level. But equally, legalism does not simply dictate decisions taken at local level, but allows for variation between different locales. Nevertheless, legalism appears to reinforce itself, in that it makes practitioners at local level think in terms of their limits rather than the leeway they have[8]. In the Scottish locality the need for *ad hoc* bargaining arises from the fact that the contract between the GP consortium and the trust only specifies the services which have to be provided by district nursing teams and, on a yearly basis, the number of staff measured in whole-time equivalents. Consequently, decisions about grade-mix, in particular, are subject to bargaining between the GP consortium, the nurse manager and the district nursing teams.

Managing district/community nursing services

The last section analysed the dynamics of the 'politics of internal boundaries', and used the features of the respective health care regime to explain differences

and similarities in the patterns of decision-making. In contrast, this and the following two sections focus on the key actors themselves, their interests and powers, and the relationship between them.

In both countries the management of district/community nursing services is dualistic in its nature, and consists of providers and purchasers. Following the prominent role played by legalism, and the highly institutionalised patterns of decision-making, in Germany purchasers and providers primarily operate at *Land* and federal level. In Britain, the relationship between purchaser and provider tends to be more localised. The arrangements in the locality, in which the research was conducted, were highly localised, as a consortium of local GP practices acts as the purchaser. Compared to Germany, therefore, the purchasers are much more directly involved in the decision-making at local level. These differing structural features have repercussions on the relationship between the two sides. As they primarily operate at *Land* and federal level, the German purchasers and providers are more distant from the day-to-day challenges of managing community nursing services, and are, therefore, under less pressure to find common solutions. As a result, their relationship tends to be adversarial. While the purchaser and provider in the Scottish locality are under similar pressures their relationship tends to be less adversarial. As the employers of district nursing staff, and as GPs who rely on district nursing services respectively, they are mutually dependent on each other. Consequently, they tend to have a strong self-interest in a constructive relationship.

The analysis of the relationship between providers and purchasers also offers interesting insights into the distribution of 'managerial orientation'. Ultimately, both sides perform 'managerial functions', defined as being concerned with the management as opposed to the delivery of services. It could be argued, though, that the GP consortium and the insurance funds as the purchasers of district/community nursing services are likely to be most interested in a cost-efficient provision of services. In contrast, the providers are likely to defend their services against cuts, and this may coincide with 'professional interests'. This is true in the case of Germany where insurance funds are preoccupied with cost containment, while providers tend to be more concerned about the protection of their services. Moreover, they partly align themselves with 'professional interests'. The underlying reason appears to be the specific managerial ethos of the provider, which also explains why the trust in the Scottish locality had a very different outlook. The local provider in Germany belongs to the group of non-profit providers (*freigemeinnützige Wohlfahrtsverbände*), which, historically, have held a dominant position in the field of community nursing services. It could be argued that their 'non-adversarial' ethos not only reflects their non-profit orientation, but also the legacy of their formerly uncontested, oligopolistic market position. This ethos is exacerbated

by an explicitly religious orientation. In addition, the influence of new public management has been much weaker than in the NHS, where it has become particularly prominent since the mid-1980s. The last aspect provides an explanation for the 'adversarial' ethos of the trust in the Scottish locality. This is echoed by the argument that the managerial reforms under the Conservative government, and the introduction of general management in particular imposed a 'non-negotiated order' on the NHS, and led to an industrial culture of 'us and them' (Cox, 1991: 106). Compared to their German counterparts the GP consortium as the purchaser also appears to be less preoccupied with cost containment. At first sight this is surprising as the GP consortium, too, is under considerable pressure due to increasing demands on care in community settings and falling funding from the health board. But the concerns of GPs for district nursing services were primarily professional in their nature, and focused on the adequacy of levels of service delivery and qualification. In this respect the dualistic role of GPs as purchasers and professionals is crucial. The latter is likely to be motivated by self-interest, as part of the increasing demands on GPs can be handed down to district nursing teams.

The relationship between district/community nurses and doctors

Feminist writers stress that the division of labour in health care is highly gendered, which is particularly reflected in the dominant position assumed by the medical profession[9]. In the context of the public health debate, though, it is pointed out that medical dominance is much weaker in non-hospital settings, which focus on non-acute interventions in the context of chronic illnesses (Schaeffer *et al.*, 1994). Regardless of their different emphasis both arguments suggest that the relationship between district/community nurses and doctors is similar across countries. An alternative argument is that their relationship depends on the health care regime in individual countries, and the role it assigns to district/community nurses and doctors respectively[10]. The evidence from the case study suggests that in both countries district/community nurses are dependent on doctors, although the type of dependence varies. Again, these differences reflect distinct approaches to the regulation of community care. The difference can be captured in the distinction between 'professional' and 'organisational dependence'. In the case of the former doctors are in a dominant position by virtue of the fact that their judgement is being regarded as professionally superior. In contrast, 'organisational dependence' denotes a situation in which doctors are in a dominant position as result of the organisationally influential role they assume.

In Germany, professional dependence prevails, which is formally set out in the respective federal legislation, the *Sozialgesetzbuch V*[11]. It defines health

care as all those interventions which, from a *medical* point of view, are necessary to cure a patient. In practice, office-based doctors not only have the power to decide whether patients need medically-related care, but also whether to delegate its delivery to community nurses. Consequently, at local level there is less need for community nurses and office-based doctors to further negotiate their relationship, and in organisational terms the two sides are independent. In contrast, as the degree of legal regulation is low in Britain, district nurses and GPs need to negotiate to a greater extent their responsibilities as well as the relationship between them. This does not mean to deny the importance of gender as an underlying structural factor, but merely to highlight the greater leeway which exists at local level. The lack of formal provisions is substituted by a much closer working relationship between district nurses and GPs, but one in which GPs assume a dominant role. This dominance primarily originates from and is sustained by the influential position GPs have in the overall organisation of health care in non-hospital settings, notably as the convenors of primary health care teams and, in the case of the Scottish locality, as purchasers.

The 'politics of internal boundaries' and the role of district/community nurses

The two preceding sections argued that managers and doctors assume an influential role in the 'politics of internal boundaries'. Indirectly, this suggested that district/community nurses are in a potentially weak position. The evidence from the case study is ambivalent: at a general level, the influence of district/community nurses appears to be weak, as the 'politics of internal boundaries' is largely dominated by purchasers and providers. But there are variations between different areas of decision-making at local level: while grade-mix is treated as a 'managerial issue', decisions about the division of labour tend to be seen as a 'nursing matter'.

Compared to the other actors district/community nurses in both countries seem to be in a weak position, although for different reasons: in Germany, the financing of health care from employer and employee contributions gives preference to their interests. As Alber (1990) argues, nurses are not only physically excluded from the corporatist arenas of health policy-making, but also none of the main actors has an interest in taking up nursing issues. While community nurses are naturally more strongly present at local level, the decision-making powers at this level are limited. This does not mean that community nurses are completely absent from the 'politics of internal boundaries', but that there is no distinct position assigned to them at federal, *Land* or local level. In contrast, in Britain decision-making is much more localised, and there are potentially greater chances for nurses to get involved. But with the purchaser-provider split, contractual arrangements have become

more important, in the completion of which district nurses do not necessarily take part. In the Scottish locality of the case study, for example, the initial 'specifications' of the scope of district nurses' practice, and the yearly contract defining the volume of services are primarily negotiated between the core group of the GP consortium and the locality management, whereas the district nursing teams are only 'consulted'.

In contrast, in the localities in both countries decisions about the division of labour appear to be left to the district/community nursing teams themselves, and are regarded as a 'nursing matter'. However, this label is deceptive, as it primarily describes the level of *direct* involvement of management. As such it ignores that decisions at the level of the team are structured by externally determined parameters. Moreover, it is not surprising that management is reluctant to get involved in the, potentially contentious, nitty-gritty of the allocation of work between differently qualified staff.

Conclusions

Implications for the understanding of occupations

In the sociology of professions, the development of occupations has long been understood as a process 'from within' the occupational group concerned, while the wider institutional structure in which occupations operate, including the potential role of the state, was neglected[12]. It is argued (McClelland, 1990) that this reflects the stereotypical assumption underlying many Anglo-American approaches that professionalism is about autonomy, and that autonomy is only possible if the state is weak. Against this background, the case study aimed at understanding a particular aspect of the occupational development of nursing by exploring whether macro-institutional structures matter, and whether countries make a difference.

The evidence from the case study stresses the importance of external factors: it suggests that the means of social closure vary not only according to the occupation's place in the division of labour (Parkin, 1979; Witz, 1992) but also between countries, in that they reflect specific 'regulatory styles': for example, following the central importance of legalism in Germany, internal boundaries are formalised by legal provisions. By contrast, in Britain the low level of legal regulation allows for credentialism and an established notion of professionalism to play a key role. Furthermore, the case study questions the understanding of professionalism as a universal phenomenon, which is the outcome of an occupational struggle. In the British case, for example, professionalism is primarily the corollary of the low level of legal regulation. At the same time, this also highlights the role institutional arrangements, and the state

in particular, play in structuring occupational strategies[13]. Finally, the evidence from the case study indicates that the process of social closure is not predetermined, but very much subject to political struggle[14]. The outcome depends on the set of actors involved, and their interests. And again, these differ between countries, as the analysis emphasised, for example, with regard to the distribution of managerial orientation.

Implications for the understanding of health care regimes

The existing literature on health care regimes largely focuses on the general mechanisms of the financing, regulation and provision of health care. It is concerned with characteristics at the level of systems. In this context Germany is described as a decentralised social insurance system[15]. Although decision-making processes are highly formalised, decision-making powers are dispersed between different levels (vertically) and between different actors (horizontally). In contrast, the structure of the NHS in Britain is more hierarchical and centralised, and decision-making powers are concentrated in the hands of the national executive[16]. Against this background the underlying aim of the case study was to turn the typologies of health care regimes up-side-down, and to ask what difference the institutional features of health care regimes make at local level.

The evidence from the case study suggests that countries do make a difference. But at the same time the differences observed seem to turn the existing typologies on their heads. The central question, then, is whether this reflects the peculiarities of the 'politics of internal boundaries' in district/community nursing, or whether it is an indication of a different, neglected face of the respective health care regime. In favour of the second point it can be argued that in Germany the vertical decentralisation of decision-making powers is confined to the federal and *Land*-level, and as a result of legalism decision-making is highly formalised. From the 'bottom-up' perspective of the local level, therefore, the 'politics of internal boundaries' must appear centralised. This is exacerbated by recent trends towards strengthening the *Land* and federal level (Alber, 1992: 163f), as well as to extending the hierarchical control by the state (Döhler and Manow-Borgwardt, 1992). At the same, time it is not only the local perspective, but also the comparison with Britain, and the Scottish locality in particular, which highlights the 'centralist aspects' of the German health care regime. In Britain, localism results from a non-legalistic approach to regulation, and has been exacerbated by the introduction of market mechanisms: the growing emphasis on local needs as the basis for service provision requires greater flexibility in terms of service organisation and management (Lightfood *et al.*, 1992: 4).

In summary, then, the 'bottom-up-perspective' adopted by the case study not only offers a fresh look at the features of individual health care regimes, but

it also points to current trends, such as localism and legalism, which are relevant beyond the specific focus on the 'politics of internal boundaries'. Thereby, it stresses the importance of 'micro-politics' for the understanding of the working of health care regimes and, in methodological terms, the need to adopt a (comparative) multi-level approach.

Notes

1 I would like to thank Richard Freeman, Gerard Murray, Alex Robertson and the participants of the conference on 'Professions, Organisations and Markets', held at Staffordshire University, 22-24 April 1998, for their comments on earlier versions of this paper.

2 The comparative approach can make potentially interesting contributions to the analysis of the 'politics of internal boundaries': it broadens the analytical perspective by offering the opportunity to explore both the uniqueness of nursing in individual countries (differences) as well as the common features across countries (similarities) (Antal *et al.*, 1987: 14). Moreover, the systematic analysis of the differences, especially at the level of health care regimes, provides a basis for explanation.

3 This refers to two interrelated trends: on the one hand more people need care, especially in non-hospital settings; on the other hand the number of potential (informal) carers is falling. For Britain, see for example Lightfood *et al.* (1992: 1), and Rathwell and Godinho (1995: 3); for Germany, see for example Schaeffer (1992: 4ff), and Schaeffer *et al.* (1994: 7ff).

4 In Germany this 'female labour of love' had strong religious undertones. Until the mid-60s community nursing, for example, was dominated by members of religious orders (Bischoff, 1994: 27ff).

5 See for example, Bischoff (1994), Davies (1995), Hugman (1991), Ostner and Beck-Gernsheim (1979), Robinson (1989).

6 This does not necessarily say anything about whether the actual boundaries between differently qualified staff are clear or blurred.

7 In both countries, this particularly refers to decisions about the division of labour, and to a lesser extent to those on grade-mix. In Britain, these decisions are much more *ad hoc* in their nature as they are much more explicitly subject to intense political struggle between the actors at local level. Further, the locality management takes an active interest in challenging 'professional certainties' about the composition of district nursing teams. In Germany, decisions about grade-mix also tend to be *ad hoc*, and are primarily influenced by the financial situation and the ethos of the local provider. But compared to decisions about the division of labour the incomplete link between the formalisation and the practice of the determining grade-mix is less obvious. A possible explanation is that the legal provisions themselves are much more vague.

8 In the interviews this was also reflected in the fact that federal health policies were considered to be highly relevant for the decision-making at the level of the local provider.

9 See for example, Bischoff (1994), Davies (1995), Hugman (1991), Ostner and Beck-Gernsheim (1979), Robinson (1989).

10 Westert (1997), for example, argues that the power of the medical profession is stronger, the weaker the degree of state involvement in health care. Similarly, Bertilsson (1990) maintains, that the influence of 'caring occupations' such as nursing depends on the extent to which 'social citizenship' has been institutionalised.

11 However, the scope of *Sozialgesetzbuch V* is limited, as it only covers medically-related care. The situation is very different in the case of basic care, regulated by *Sozialgesetzbuch XI*, whose scope is purely defined in legal terms, and which is delivered independently of medical delegation. The influence of office-based doctors may diminish in the future with more and more care being defined as basic care.

12 For an overview of the debate see Freidson (1994).

13 On the analytical conceptualisation of the relationship between state and professions see Johnson (1995), and Light (1995).

14 Similarly Burrage *et al.* (1990), and Light (1995).

15 See for example Moran (1994).

16 See for example Wilsford (1994).

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The politics of internal boundaries – a comparative analysis of community nursing in Britain and Germany.

Some preliminiary observations

Viola Burau

Over recent years health care systems across Europe have experienced a renewed emphasis on care in community settings. These developments reflect not only demographic and epidemiological changes, but also the policy-driven trend towards de-hospitalisation. More specifically, reforms of community care have focused on cost and efficiency in the context of a contractual culture. These policy initiatives potentially formalise the practice of community nurses, and challenge the internal boundaries between them. Internal boundaries are central to both managers and professionals: with financial and demand pressures decisions as to who is in a team, and who does what become more important. Similarly, decisions about internal boundaries are at the core of the professional debate about what community nursing does, and what it is.

These challenges also raise interesting questions about the underpinning decision-making processes, that is the "politics of internal boundaries". It can be understood as the process, by which internal boundaries are set-up, maintained and controlled, and by which the occupational territory of the "core" of community nursing is demarcated from that of its "fringes".[1] However, these "fringe care workers" '... form ambiguous satellites to the caring profession, being neither entirely distinct, nor entirely integrated.' (Hugman, 1991: 94).

In the context of this study, the politics of internal boundaries is explored by looking at Britain and Germany, which have seen major reforms of community care in recent years.[2] The comparative

approach can make interesting contributions to the analysis: while both countries are confronted with similar challenges, the institutional contexts of health care differ, and offer a potential source of explanations.[3] The study focuses on the approaches and dynamics of decision making as well as on the actors involved, that is their interests, resources and the power relationships between them. Here, internal boundaries are operationalised by focusing on the mix of different grades of community nurses and the division of labour between them.

The first section outlines the organisation of community care in Britain and Germany, and discusses recent reforms. In contrast, the following two sections are based on an study of two local providers of community care, and analyse how decisions about internal boundaries are taken, and who is involved. Finally, the conclusions summarise how recent reforms of community care have influenced the politics of internal boundaries, and explore the study's implications for the theoretical understanding of occupations and health systems.

Organisation and reform of community care

Although in both Britain and Germany community care has traditionally been regarded as the "poor relation" of health care,[4] it has become a topical issue. The debate about community care dates back to the early 1970s, and the critique of institutionalised care. However, it has received new impetus by demographic and epidemiological changes, which are seen to increase the demand for care in non-acute care settings,[5] and by trends towards de-hospitalisation, aiming to reduce the length of stay in hospitals. Paradoxically, the potential expansion of community care takes place in a general climate of financial austerity.

Britain

In Britain, community (health) care is part of the National Health Service (NHS), which is financed out of general taxation.[6] Following the introduction of a quasi-market in health care in 1991, self-governing trusts are the providers of community care. Their services are purchased by health authorities, or, more recently, general practitioners. Community care is delivered by different

types of nursing staff. These include district nurses, who tend to focus on care of the elderly, health visitors, who primarily deal with health education and child care, and school nurses, who are concerned with health education of school children. Another important feature of community care is the complex interface between community health care, which is part of the NHS, and community social care, which is administered by Social Services Departments of local authorities. As part of the 1991 reform, there has been greater emphasis on co-operation between different agencies and occupations: 'The ambition is hardly new, but the emphasis in the 1990s on making services more responsive to users' needs has resulted in a new push for collaboration.' (Lewis and Glennerster, 1996: 165). Moreover, in the context of the promotion of a "primary care-led NHS" (Department of Health, 1996) general practitioners have assumed an increasingly important role in community care services. They have started to employ their "own" nurses, the so-called practice nurses, whose work partly overlaps with those of community nurses (Lightfood et al. 1992: 3). Moreover, since 1993 most GPs can also directly purchase community nursing care (Traynor and Wade 1994: 3).

The organisation of community nursing services varies. The trust the study looked at consisted of two separate localities, each of which were headed by a locality director, who had general management responsibilities, and a nurse manager. Each locality had a number of nursing teams, which formed part of the primary health care team of individual general practices. The general practitioners in the locality had formed a consortium, which purchased community nursing services from the trust.

Germany

Traditionally, community care in Germany had been at the margins of social policy, being predominantly financed through social assistance. However, this has changed: in 1989 the coverage of the health insurance was extended to include medically-related aspects of community care (Dieck 1994: 259ff). More importantly, 1995 saw the establishment of a new branch of the social insurance system, which specially focuses community care.[7] The long-term care insurance (*Pflegeversicherung*) is financed by employer and employee contributions, paid on monthly earnings; contribution rates are fixed and the overall expenditure is capped. The

Pflegeversicherung is administered by self-governing, statutory insurance funds (*Pflegekassen*), which act as the purchasers of community care. The continued co-existence of coverage provided by the long-term and health insurance care manifests itself in the distinction between basic and medically-related care (*Grund-* and *Behandlungspflege*). This has important implications for the internal boundaries in community nursing, due to significant differences in the formal qualification requirements. The provision of community care is heterogeneous, traditionally encompassing a wide range of non-profit providers (*freigemeinnützige Träger*). However, the long-term care insurance has opened the market to include private, for-profit providers. Community care is delivered by staff with a general nursing qualification (*Krankenpflege*) or with a social care-oriented qualification in care of the elderly (*Altenpflege*).

Again, the organisation of community nursing services varies. The religiously-oriented provider the study looked at was headed by a general manager. It included three nursing teams, which covered different geographical areas. In many instances the teams had to liase with the office-based doctors of their patients.

THE POLITICS OF INTERNAL BOUNDARIES – HOW?

Between formalisation "from above" and local decisions – approaches to setting internal boundaries

The study suggests that the approaches to setting internal boundaries in community nursing differ.[8] In the case of the division of labour decision making at the level of the local provider and teams is combined with formalisation "from above", that is legalism in Germany, and credentialism and a well-established notion of professionalism in Britain. In contrast, the grade-mix is much more subject to local, *ad hoc* decision-making.

In Germany, legislation at federal, and to some extent at state level contains provisions about the division of labour in community nursing. These are formulated in terms of minimum standards, and vary between different types of care, that is medically-related and basic care respectively. As these provisions are part of the general contract (*Versorgungsvertrag*) between insurance funds and local providers the federal and the local level are closely connected. The important role played by legalism is stengthened

as the structure of credentials in community nursing is characterised by a low degree of differentiation, notably a dualistic distinction between qualified and non-qualified staff.

In Britain legal provisions only provide a general framework, and the central strategies for formalising the division of labour "from above" are credentialism, and a well-established notion of professionalism are central strategies. The United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC), the regulatory body of nursing, plays a potentially powerful role in regulating the division of labour. While its code only defines practice in procedural terms, it coexists with a vertically and horizontally differentiated structure of qualifications in community nursing. Moreover, even though the codes and guidelines of the UKCC do not apply to non-registered community nursing staff, it indirectly draws a strong distinction between qualified and non-qualified staff. Similarly, non-qualified staff have been included more directly in the credentialist strategy, through the introduction of a statutory framework for vocational qualifications.

But legalism and credentialism/professionalism only provide *frameworks* for decision-making at the level of the locality. In Germany, although legalism formally ensures a close relationship between federal and local level, its provisions appeared to be external to the practice of community nurses. The incomplete (mutual) permeation of legal provisions and practice particularly manifested itself in decisions about the division of labour, notably in intense discussions at the level of the team about the scope of practice of unqualified members of staff.

In Britain, the formalisation of the division of labour via credentialism/professionalism seemed to reach down to the local level, providing criteria for decision-making within the district nursing teams. Consequently, decisions tended to be more formal, and assumed a much less prominent role than in the German teams. Nursing auxiliaries, for example, were seen in a clearly subordinate position, and decisions about what they could do appeared to be clear-cut.

In comparison, in both countries decisions about grade-mix appeared to be more localised and *ad hoc*. In the British locality, for example, these decisions were subject to intense political struggle between the actors at local level. Further, the locality management took an active interest in challenging "professional certainties" about the composition of district nursing teams. In the case of the

German locality, *ad hoc* decisions about grade-mix were primarily influenced by the financial situation and the ethos of the local provider. But compared to decisions about the division of labour this was not so much due to an incomplete link between law and practice, but due to the vagueness of legal provisions themselves.

Negotiating contracts and beyond – the dynamics of decision-making

In both countries contractual arrangements play an important role in community care. Whereas this is an established feature of the health care system in Germany, it is a more recent phenomenon in Britain, which is closely related to the introduction of the internal market. Decision making, therefore, often took the form of negotiating contracts, and as such tended to be formal as opposed to *ad hoc*. Despite these similarities the degree of standardisation and the level of decision making differed.

In Germany, decision making is highly standardised. The federal legislation, that is the *Sozialgesetzbuch V* and *XI*, not only contain provisions about community nursing services, but also procedural regulation about the remit of decision-making processes and contracts at federal and at state level. The implicit standardisarion is exacerbated by the fact that apart from the completion of the basic contract (*Versorgungsvertrag*) local providers are not directly involved in decision-making.

In Britain the situation was almost the reverse, and decision-making tended to be more localised and less standardised. Moreover, the locality, in which the research was conducted, was an interesting example of the current trend towards decentralisation in the NHS: at the level of the locality a general practitioner consortium acted as the purchaser of district nursing services, negotiating and completing contracts with the trust. While the consortium received funding from the health authority, it had considerable freedom when it came to the negotiations with the trust.

However, as contracts are not exhaustive in their nature formal negotiation co-existed with *ad hoc* decision making at the level of the locality. In Germany this reflects the dualistic approach taken by the long-term care insurance, which combines legalistic and market mechanisms. Although the legislation contains provisions about the grade-mix and the division of labour in community

nursing, these take the form of minimal standards, and allow for considerable room for manouevre at local level. At the same time, the insurance funds are reluctant to further specify standards. The meaning of legalism at local level, then, was paradoxical: the strong element of standardisation inherent in legalism resulted in a close relationship between federal and local level. But equally, legalism does not simply dictate decisions taken at local level, but allows for variation between different locales. Interestingly, though, the study suggests that legalism reinforces itself, in that it made practitioners at local level think in terms of their limits rather than the leeway they have.

In the locality in Britain the need for *ad hoc* bargaining arose from the fact that the contract between the general practitioner consortium and the trust only specified the services which had to be provided by district nursing teams, and, on a yearly basis, the number of staff measured in whole-time equivalents. While the division of labour was mainly regarded as the "business" of the district nursing teams, and possibly the nurse manager, decisions about grade-mix were more strongly subject to bargaining between the general practitioner consortium, the nurse manager and, to some extent, the district nursing teams.

THE POLITICS OF INTERNAL BOUNDARIES – WHO?

The last section analysed the "how" of the politics of internal boundaries, and relates these to the features of the respective health system. In contrast, this section focuses on the key actors themselves, their interests, strategies and resources, and the power relationship between them.

Managers

Following the contractual model in both countries the management of community nursing services is dualistic in its nature, consisting of providers and purchasers. In Germany they operate at state and federal levels, while in Britain the relationship between the two tends to take place at local level. The arrangements in the locality, in which the research was conducted, were particularly localised, as a consortium of local general practices acted as the purchaser. These different structural features have interesting repercussions

on the relationship between the contractual parties. As they primarily operate at state and federal level, purchasers and providers in Germany were more distant from the day-to-day management of community nursing services. As they were under less pressure to find common solutions their relationship tended to be adversarial, especially when negotiating fees in the present context of resource and demand pressures. While the purchaser and provider in the British locality were under similar pressures they had a stronger self-interest in a constructive relationship: as the employers of district nursing staff, and as general practitioners who rely on district nursing services respectively, they were mutually dependent on each other.

The analysis of the relationship between providers and purchasers also offers interesting insights into the distribution of "managerial orientation". Although both sides perform managerial functions the general practitioner consortium and the insurance funds as the purchasers of community nursing services are likely to be most interested in a cost-efficient provision of services. In contrast, the providers are likely to defend "their" services against further financial cuts.

This was true in the case of Germany, where insurance funds were preoccupied with cost containment, while providers tended to be more concerned about the protection of their services. At the level of argument they partly aligned themselves with the "professional" interests of nurses. The underlying reason appears to be the specific managerial ethos of the local provider, which was part of a group of non-profit providers (*freigemeinnützigen Wohlfahrtsverbände*). It could be argued that its non-adversarial ethos not only reflected its non-profit orientation, but also the legacy of a formerly uncontested, oligopolistic market position. More generally, it also has to be taken into account, that the influence of new public management has been much weaker than in the NHS, where it has become particularly prominent since the mid-1980s.

The last aspect provides an explanation for the adversarial ethos of the trust in the British locality. The underlying argument is that the managerial reforms under the Conservative government, and the introduction of general management in particular, imposed a "non-negotiated order" on the NHS, leading to an industrial culture of "us and them" (Cox 1991: 106). Similarly, there was an interesting contrast between the orientation of the German

insurance funds and that of the general practitioner consortium in the British locality, which was much less preoccupied with cost containment and efficiency. At first sight this was surprising as the general practitioner consortium, too, was under similar pressures. Interestingly, though, the general practitioners' concerns for district nursing services were primarily 'professional' in their nature, and focused on the adequacy of levels of service delivery and qualification. In this respect the dualistic role of general practitioners as purchasers and professionals appears to be crucial. However, the stance taken by the general practitioners is also likely to be motivated by self-interest, insofar as part of the increasing demands on general practitioners can potentially be handed down to district nursing teams.

Doctors

Not surprisingly, the evidence from the study suggests that in both countries community nurses are dependent on doctors. While this ultimately goes back to the gendered nature of the division of labour in health care, it manifests itself in different ways. In the case of "professional dependence" the dominant position of doctors is reflected in the professional superiority which is assigned to medical decisions. In contrast, in the case of "organisational dependence" the dominance of doctors particularly manifests itself the organisationally influential role they assume in the context of community care.

In Germany, professional dependence prevails, and is formally set out in the respective federal legislation, the *Sozialgesetzbuch V.*[9] It defines health care as all those interventions which, from a *medical* point of view, are necessary to cure a patient. In practice, office-based doctors not only have the power to decide whether patients need medically-related care, but also whether to delegate its delivery to community nurses. In organisational terms, then, there was less need for community nurses and office-based doctors to further negotiate their relationship at local level.

In Britain, there was greater need for negotiation due to the lack of formal provisions. These were substituted by a much closer working relationship between district nurses and general practitioners. Here, general practitioners assumed a dominant role, which was particularly reflected in their influential position in the overall organisation of non-hospital settings. In the locality of

the study the district nurses were not only part of primary health care teams, which were based in individual general practices, but their services were also purchased by general practitioners.

Community nurses

So far it has been argued that managers and doctors assumed an influential role in the politics of internal boundaries, suggesting that community nurses were in a potentially subordinate position. The evidence from the study is ambivalent: at a general level, the influence of community nurses appeared to be weak. But, interestingly, there were variations between different areas of decision-making at local level: while grade-mix was treated as a "managerial issue", decisions about the division of labour tended to be seen as a "nursing matter".

Compared to the other actors community nurses in both countries seemed to be in a weak position. Leaving the gendered nature of the division of labour in health aside, this reflects the dominance of the contractual model in community care: in Germany, the financing of health care from employer and employee contributions gives preference to the interests of financiers, and is sustained by a closed-shop corporatist model of decision making. As Alber (1990) argues, nurses are not only physically excluded from these formal arenas, but also none of the main actors has an interest in taking up nursing issues. Instead, in the existing context of resource contraints, they are likely to be preoccupied with issues of costs. Similarly, although community nurses were more strongly present at local level, the decision-making powers at this level were limited, following the standardising and centralising effects of the prevailing legalistic approach. This does not mean to say that community nurses were completely absent from the politics of internal boundaries, but that there was no distinct position assigned to them.

In Britain, decision making was much more localised, and there were potentially greater chances for nurses to get involved. But with the purchaser-provider split, contractual arrangements have become more important, in the completion of which district nurses do not necessarily take part. In the British locality, for example, the initial specifications of the scope of district nurses' practice, and the yearly contract defining the volume of services were primarily negotiated between the general practitioner

consortium and the locality management, whereas the district nursing teams were only "consulted". Beyond this formal arena of decision-making, the general practitioner consortium and individual general practices also had considerable influence on more informal negotiating processes, such as in the context of filling a vacancy.

Interestingly, however, in both countries decisions about the division of labour appeared to be regarded as a "nursing matter". This is not surpising, as management appeared to be reluctant to get involved in the nitty-gritty of allocating work. However, this label is deceptive, as it primarily describes the level of *direct* involvement of the management of local providers. As such, it ignores that decisions at the level of the team were structured by externally determined parameters, like funding, and by the interests of purchasers and providers. In the case of the British locality this can also be interpreted as a verbal tribute to the notion of professionalism, and the independence of district nurses' practice.[10] The underlying argument is that the notion of professional autonomy is treated as sacrosanct at the level of discourse, whereas it is a myth at the level of practice. However, the core of professionalism may not be autonomy, but the acceptance of professional boundaries. In the case of community nursing, however, these boundaries appeared to reflect to a considerable extent the preferences of general practitioners, and their concern to reduce their own workloads.

Conclusions

The reform of community care and the politics of internal boundaries

The reforms of community care in Britain and Germany have emphasized the importance of cost efficiency and containment within a broader framework of contractural relationships. While the "public contract model" (OECD 1992) has been a traditional characteristic of the organisation of health care in Germany, it is a more recent feature of the NHS and the internal market in Britain. The combination of a contractual culture and cost pressures encourages greater transparency of the internal boundaries in community nursing, that is a clearer definition of the scope and contents of its practice, as well as of the type of staff providing care.[11] This is particularly the case as personnel costs account for

the majority of health care expenditure, and as nursing is the single largest occupation within health care.

As the study shows, in both countries the division of labour in particular is subject to formalisation, although in different ways, reflecting the broader institutional context of health care. In Germany, the framework of legalism was central, especially as it provided the basis for a multi-layered system of contracts. In Britain, by contrast, formalisation was promoted by credentialism and an established notion of professionalism. However, formalisation "from above" was not complete, and there was scope for decisions at the local level. This was also true of decisions about the grade-mix in community nursing teams. But in the case of both the division of labour and grade mix, the room for manoeuvre is ultimately limited by externally determined resource constraints.

Moreover, although decisions about internal boundaries have become more important, community nurses seem to have been marginalised. Even though the day-to-day allocation of work, for example, was largely left to the teams, it was strongly influenced by the interests of the contractual parties. Nurses were excluded from this system of negotiation. This is particularly significant as decisions about who is in a team, and who does what have become more contentious in the context of cost pressures and increasing demands. However, in part the purchasers, in the case of the British locality, and the providers, in the case of the locality in Germany, aligned themselves with the (perceived) interests of community nurses, and potentially mitigates negative impacts on community nurses.

Implications for the understanding of occupations

In the sociology of professions, the development of occupations has long been understood as a process "from within" the occupational group concerned, while the wider institutional structure in which occupations operate, including the potential role of the state, has tended to be neglected.[12] It could be argued (McClelland 1990) that this reflects the stereotypical assumption underlying many Anglo-American approaches, that professionalism is about autonomy, and that autonomy is only possible if the state is weak. Against this background the study aimed at understanding a particular aspect of the occupational

governance of nursing by exploring whether macro-institutional structures matter, and whether countries make a difference.

The evidence from the study questions the notion that professionalism is generic. Instead it stresses the importance of the insititutional context of health care: it suggests that the means of social closure not only vary according to the occupation's place in the division of labour (Parkin 1979; Witz 1992), but also between countries. Following the central importance of legalism in Germany, for example, the division of labour was formalised by legal provisions. By contrast, in Britain the low level of legal regulation allows for credentialism and an established notion of professionalism to play a key role. Professionalism, then, is primarily the corollary of a specific regulatory style, as opposed to being the result of occupational struggles. Moreover, the evidence from the study indicates, that the process of social closure is not predetermined, but very much subject to political struggle, particularly of the contractual parties.[13] The outcome depends on the set of actors involved, and their interests. And again, these differ between countries, for example, with regard to the distribution of managerial orientations.

Implications for the understanding of health care systems

The existing literature on health care systems largely focuses on the general mechanisms of the financing, regulation and provision of health care. It is concerned with characteristics at the level of systems. In this context Germany is described as a decentralised social insurance system.[14] Although decision-making processes are highly formalised, decision-making powers are dispersed between different levels (vertically) and between different actors (horizontally). In contrast, the structure of the NHS in Britain is characterised as being more hierarchical and centralised, and decision-making powers are concentrated in the hands of the national executive.[15] Against this background the underlying aim of the study was to turn the typologies of health care systems up-side-down, and to ask what difference the institutional features of health care systems make at local level.

The analysis of the politics at local level suggests that countries do make a difference. However, the differences observed seem to turn the existing typologies on their heads. The central question, then, is whether this reflects the peculiarities of the study, or

whether it is an indication of a different, neglected face of the respective health care system. In favour of the second view it can be argued that, in Germany not only is the vertical decentralisation of decision-making powers confined to the federal and state-level, but legalism also makes decision-making more formalised. From the "bottom-up" perspective of the local level, therefore, the politics of internal boundaries must appear centralised. This is exacerbated by recent trends towards strengthening the state and federal level (Alber 1992: 163ff), and towards extending the hierarchical control by the state (Döhler and Manow-Borgwardt 1992). At the same time, the comparison with Britain, and the specific locality highlights the centralist aspects of the German health care system. In Britain, localism results from a non-legalistic approach to regulation, and has been exacerbated by the introduction of market mechanisms: the growing emphasis on local needs as the basis for service provision requires greater flexibility in terms of service organisation and management (Lightfood et al 1992: 4). However, this goes hand-in-hand with the centralisation of policy development and budgetary control: 'Responsibility now lies with a large number of smaller agencies. The rhetoric is about devolution, local autonomy and diversity, but central government nevertheless continues to dictate the agenda.' (Allsop 1995: 188).

In summary, then, the "bottom-up-perspective" adopted by the study not only offers a fresh look at the features of individual health care systems, but it also points to current trends, such as localism and legalism, which are relevant beyond the specific focus on the politics of internal boundaries. Thereby, it stresses the importance of micro politics for the understanding of the working of health care system, and, in methodological terms, the need to adopt a (comparative) multi-level approach.

Footnotes

[1] The understanding of internal boundaries is broadly based on the neo-Weberian concept of social closure (see Parkin 1979; Witz 1992).

[2] The study is part of ongoing research. The empirical work focused on a community trust in Scotland, and a local provider in Northrhine-Westphalia. It consisted of focus groups with two community nursing teams in each locality, and expert interviews with the management of the trust/local provider, with the general practitioner consortium and the insurance fund as the purchaser, and with the senior partners of the relevant general practices. For a similar discussion of the study see Burau (forthcoming).

[3] For a general overview of the comparative method see Satori (1994).

[4] For Britain see Means and Smith (1998); for Germany see Dieck (1994).

[5] This refers to two interrelated trends: on the one hand more people need care, especially in non-hospital settings; on the other hand the number of potential (informal) carers falls. For Britain, see Rathwell and Godinho (1995: 3); for Germany, see Schaeffer et al. (1994: 7ff).

[6] For an overview of the British NHS see Baggot (1998).

[7] For an overview see Meyer (1996).

[8] The study focused on community nursing care for the elderly. Whereas in Britain this type of care is primarily delivered by district nursing staff, in Germany a whole range of different community nursing staff is involved. The use of terminology, therefore, differs depending on which country is referred to. Where nursing in both countries is concerned the more generic term of "community nurses" is used.

[9] However, the scope of *Sozialgesetzbuch V*, which concerns the health insurance, is limited, as it only covers medically-related care. The situation is very different in the case of basic care, which falls under the remit of the long-term care insurance, and which is regulated by *Sozialgesetzbuch XI*. The scope of basic care is purely defined in legal terms, and it is delivered independently of medical delegation. The influence of office-based doctors may diminish in the future with more and more care being defined as basic care.

[10] There was no comparable reference in the case of Germany, as legalism acted as the functional equivalent to the established notion of professionalism in Britain.

[11] For Britain see Buchan and Ball (1991); for Germany see Meyer (1996).

[12] For an overview of the debate see Freidson (1994).

[13] Similarly Burrage et al. (1990), and Light (1995).

[14] For an overview see Moran (1994).

[15] For an overview see Wilsford (1994).